

2000 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # P99000109506

1. Entity Name

LOVIN CARE MEDICAL SERVICES & SUPPLIES INC.

Principal Place of Business

31 TAMiami CANAL ROAD
SUITE 2
MIAMI FL 33144

Mailing Address

31 TAMiami CANAL ROAD
SUITE 2
MIAMI FL 33144

2. Principal Place of Business

3. Mailing Address

6050x52057x

Suite, Apt. #, etc.

Suite, Apt. #, etc.

MIAMI FL

City & State

City & State

Zip

Country

Zip

33152-0574 USA

Country

4. FEI Number

65-0985894

Applied For

Not Applicable

5. Certificate of Status Desired

☐

\$8.75. Additional Fee Required

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

BATISTA, SONIA
9460 SW 81 STREET
MIAMI FL 33173

Name

Street Address (P.O. Box Number is Not Acceptable)

City

FL

Zip Code

8. The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida.

SIGNATURE

Signature, typed or printed name of registered agent and title if applicable.

(NOTE: Registered Agent signature required when reinstating)

DATE

7-12-00

9. This corporation is eligible to satisfy its intangible tax filing requirement and elects to do so. (See criteria on back) ☐

FILE NOW!!! FEE IS \$550.00
After SEPTEMBER 13, 2000 Min. will be \$750.00
Make Check Payable to Department of State

10. Election Campaign Financing Trust Fund Contribution. ☐

\$5.00 May Be Added to Fees

11. OFFICERS AND DIRECTORS

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE	PD	<input type="checkbox"/> Delete
NAME	BATISTA, SONIA	
STREET ADDRESS	9460 S.W. 81ST STREET	
CITY-ST-ZIP	MIAMI FL 33173	
TITLE	VD	<input type="checkbox"/> Delete
NAME	PAGES, MERCEDES C	
STREET ADDRESS	8305 SW 152ND PL #515	
CITY-ST-ZIP	MIAMI FL 33193	
TITLE		<input type="checkbox"/> Delete
NAME		
STREET ADDRESS		
CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Delete
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STREET ADDRESS		
CITY-ST-ZIP		

TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
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CITY-ST-ZIP		
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TITLE		<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME		
STREET ADDRESS		
CITY-ST-ZIP		

13. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(i), Florida Statutes. I further certify that the information indicated on this report or supplemental report is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am an officer or director of the corporation or the receiver or trustee empowered to execute this report as required by Chapter 607, Florida Statutes; and that my name appears in Block 11 or Block 12 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE:

SIGNATURE REQUIRED

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

7-12-00

FILED
Aug 17, 2000 8:00 am
Secretary of State

07-19-2000 90022 019 ***150.00



DO NOT WRITE IN THIS SPACE

7-12-00

Mr. Louis Lee Medical Services &
Supplies Inc.
Sleeve

Gentlemen;

Attached is my \$150.00
check because I never
received any other correspondence
from your organization. Please
accept this check as my
payment.

thurs.

