

2003 FOR PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

FILED
Mar 17, 2003 8:00 am
Secretary of State

03-17-2003 90480 028 ***150.00

DOCUMENT # P99000110024

1. Entity Name
AMERICA'S ORAL & FACIAL SURGERY, INC.



Principal Place of Business
302 N.W. 179TH AVENUE
SUITE 201
PEMBROKE PINES FL 33029

Mailing Address
302 N.W. 179TH AVENUE
SUITE 201
PEMBROKE PINES FL 33029

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Zip

Country

Zip

Country

4. FEI Number **65-1018865**

Applied For

Not Applicable

5. Certificate of Status Desired ☐

**\$8.75 Additional
Fee Required**

☐ CHECK HERE IF MAKING CHANGES

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

ARROYO, JUAN DR.
302 N.W. 179TH AVENUE
SUITE 201
PEMBROKE PINES FL 33029

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. I am familiar with, and accept the obligations of registered agent.

SIGNATURE

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

(NOTE: Registered Agent signature required when reinstating)

DATE

FILE NOW!!! FEE IS \$150.00
After May 1, 2003 Fee will be \$550.00
Make Check Payable to Florida Department of State

9. Election Campaign Financing ☐ **\$5.00 May Be
Trust Fund Contribution. Added to Fees**

10. OFFICERS AND DIRECTORS

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE **PSD** ☐ Delete
NAME **ARROYO, JUAN C DMD**
STREET ADDRESS **13780 SW 122 COURT**
CITY-ST-ZIP **MIAMI FL 33186**

TITLE ☐ Change ☐ Addition
NAME _____
STREET ADDRESS _____
CITY-ST-ZIP _____

TITLE **VPTD** ☐ Delete
NAME **PASTRANA, MIGUEL A DMD MD**
STREET ADDRESS **13834 SW 122 COURT**
CITY-ST-ZIP **MIAMI FL 33186**

TITLE ☐ Change ☐ Addition
NAME _____
STREET ADDRESS _____
CITY-ST-ZIP _____

TITLE **P** ☐ Delete
NAME **ARROYO, JUAN C DMD**
STREET ADDRESS **15823 SW 10 ST**
CITY-ST-ZIP **PEMBROKE PINES FL 33027**

TITLE ☐ Change ☐ Addition
NAME _____
STREET ADDRESS _____
CITY-ST-ZIP _____

TITLE **VPP** ☐ Delete
NAME **PASTRANA, MIGUEL A MD**
STREET ADDRESS **1062 SW 159 DR**
CITY-ST-ZIP **PEMBROKE PINES FL 33027**

TITLE ☐ Change ☐ Addition
NAME _____
STREET ADDRESS _____
CITY-ST-ZIP _____

TITLE ☐ Delete
NAME _____
STREET ADDRESS _____
CITY-ST-ZIP _____

TITLE ☐ Change ☐ Addition
NAME _____
STREET ADDRESS _____
CITY-ST-ZIP _____

TITLE ☐ Delete
NAME _____
STREET ADDRESS _____
CITY-ST-ZIP _____

TITLE ☐ Change ☐ Addition
NAME _____
STREET ADDRESS _____
CITY-ST-ZIP _____

12. 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 10 or Block 11 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

3/12/03 (954) 438-8448

Date Daytime Phone #

CR2E034 (10/02)