

# 2001 UNIFORM BUSINESS REPORT (UBR)

**FILED**  
**Aug 15, 2001 8:00 am**  
**Secretary of State**

08-15-2001 90001 005 \*\*\*150.00

**DOCUMENT # S85656**

1. Entity Name  
**HEMOCARE OF SOUTH FLORIDA, INC.**

Principal Place of Business

**4564 MARKS WAY  
 LAKE WORTH FL 33463**

Mailing Address

**4564 MARKS WAY  
 LAKE WORTH FL 33463**

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 **65-0291145**

Applied For  
 Not Applicable

5. Certificate of Status Desired ☐ **\$8.75 Additional Fee Required**

DO NOT WRITE IN THIS SPACE



6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

**FLYNN, BARBARA ANN  
 4564 MARKS WAY  
 LAKE WORTH FL 33463**

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

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 12, 2001 Fee 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 ☐ Delete  
 NAME **D FLYNN, BARBARA ANN**  
 STREET ADDRESS **4564 MARKS WAY**  
 CITY-ST-ZIP **LAKE WORTH FL**

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

TITLE ☐ Delete  
 NAME **T BEDDINGTON, NELLIE OWEN**  
 STREET ADDRESS **4564 MARKS WAY**  
 CITY-ST-ZIP **LAKE WORTH FL** **DECEASED**

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

TITLE ☐ Delete  
 NAME  
 STREET ADDRESS  
 CITY-ST-ZIP

TITLE ☐ Change ☐ Addition  
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TITLE ☐ Delete  
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TITLE ☐ Change ☐ 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: *Barbara Flynn* **BARBARA FLYNN** 8-11-01 5619640253  
 SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CR2E034 (5/01)

HOME CARE OF SOUTH FLORIDA, INC.  
4564 MARKS WAY  
LAKE WORTH, FLORIDA 33463

561/964-0253 • FAX: 561/439-7928

attachment  
P# 885656 Payer  
A0081146

7-24-01

DEAR SIR/MADAM

I AM SO SORRY I NEGLECTED TO PAY THE  
CORPORATE FEE ON TIME THIS YEAR, USUALLY  
IT IS SENT OUT WITHIN THE MONTH, HOWEVER  
THIS PAST DECEMBER MY MOTHER PASSED AWAY  
AND FOR MORE THAN THREE MONTHS THINGS WERE  
VERY HARD, IN THE PROCESS THE PAPERS WERE  
• MISPLACED.

I SPOKE TO ONE OF YOUR OPERATORS AND SHE  
SAID TO SEND A NOTE WITH \$150.00

I WANT TO THANK YOU SO VERY MUCH FOR THE  
EMPATHY THAT WAS SHOWN TO ME BY THIS  
PARTICULAR OPERATOR

SINCERELY/

Barbara Elyhu