
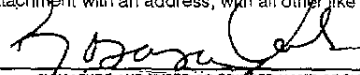


2005 FOR PROFIT CORPORATION ANNUAL REPORT (AR)

FILED
Apr 06, 2005 08:00 AM
Secretary of State

DOCUMENT # V54917					
1. Entity Name MASTERCARE MEDICAL SUPPLIES, INCORPORATED					
Principal Place of Business 175 FONTAINEBLEAU BLVD. SUITE 1-N-5 MIAMI FL 33172 US			Mailing Address 175 FOUNTAINEBLEAU BLVD. SUITE 1-N-5 MIAMI FL 33172 US		
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 65-0369696	
				Applied For Not Applicable	
5. Certificate of Status Desired <input checked="" type="checkbox"/>			8.75 Additional Fee Required		
6. Name and Address of Current Registered Agent			7. Name and Address of New Registered Agent		
SOSA, ROSAURA A 175 FONTAINEBLEAU BLVD{ SUITE 1-N-5 MIAMI FL 33172			Name		
			Street Address (P.O. Box Number is Not Acceptable)		
			400000290205 04/06/05-80056-021 158.75		
			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 _____ (NOTE: Registered Agent signature required when reinstating)					
FILE NOW!!! FEE IS \$150.00 After May 1, 2005 Fee Will Be \$550.00 Make Check Payable to Florida Department of State					
9. Election Campaign Financing Trust Fund Contribution <input type="checkbox"/>				85.00 May Be Added to Fees	
10. OFFICERS AND DIRECTORS			11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11		
TITLE	P	<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME	SOSA, ROSAURA A.		NAME		
STREET ADDRESS	175 FONTAINEBLEAU BLVD., SUITE 1-N-5		STREET ADDRESS		
CITY-ST-ZIP	MIAMI FL		CITY-ST-ZIP		
TITLE	S	<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME	SOSA, ROSAURA A		NAME		
STREET ADDRESS	175 FONTAINEBLEAU BLV., STE 1-N-5		STREET ADDRESS		
CITY-ST-ZIP	MIAMI FL		CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME			NAME		
STREET ADDRESS			STREET ADDRESS		
CITY-ST-ZIP			CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME			NAME		
STREET ADDRESS			STREET ADDRESS		
CITY-ST-ZIP			CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME			NAME		
STREET ADDRESS			STREET ADDRESS		
CITY-ST-ZIP			CITY-ST-ZIP		
TITLE		<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change	<input type="checkbox"/> Addition
NAME			NAME		
STREET ADDRESS			STREET ADDRESS		
CITY-ST-ZIP			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: 			Date: 4/4/05 Phone: 305-229-1770		
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR			Daytime Phone #		