

SECOND NOTICE: CORPORATION WILL BE DISSOLVED ON OR AFTER AUGUST 7, 1996.
AMOUNT DUE ON OR BEFORE 8/7/96: \$225 (IF DISSOLVED, MINIMUM AMOUNT DUE TO REINSTATE: \$375.)

PROFIT
CORPORATION
ANNUAL REPORT
1996



FLORIDA DEPARTMENT OF STATE
Sandra B. Mortham
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # F46237 (6)

1. Corporation Name

DELTONA CHIROPRACTIC CLINIC, P.A.



Principal Place of Business

Mailing Address

% LESTER N LEVINE
1240 NORMANDY BLVD.
DELTONA FL 32725

% LESTER N LEVINE
1240 NORMANDY BLVD.
DELTONA FL 32725

3. Date Incorporated or Qualified

09/28/1981

3a. Date of Last Report

04/27/1995

4. FEI Number

59-2139891

Applied For

Not Applicable

5. Certificate of Status Desired

\$8.75 Additional
Fee Required

6. Election Campaign Financing
Trust Fund Contribution

\$5.00 May Be
Added to Fees

8. This corporation has liability for intangible tax under s. 199.032,
Florida Statutes

Yes No

2. Principal Place of Business

2a. Mailing Address

21 Suite, Apt. #, etc.

26 Suite, Apt. #, etc.

22 City & State

27 City & State

23 Zip

Country

28 Zip

Country

24

25

29

30

9. Name and Address of Current Registered Agent

10. Name and Address of New Registered Agent

LEVINE, LESTER N
1240 NORMANDY BLVD.
DELTONA FL 32725

81 Name

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

83

84 City

FL

85 Zip Code

11. Pursuant to the provisions of Sections 607.0502 and 607.1508, Florida Statutes, the above-named corporation submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with, and accept the obligations of, Section 607.0505, Florida Statutes.

SIGNATURE

Signature (typed or printed name of registered agent and the applicable fee)

(If Applicable) Registered Agent Signature Required when reinstating

Date

12. OFFICERS AND DIRECTORS

13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12

TITLE PD
NAME LEVINE, LESTER N
STREET ADDRESS 1856 WINGFIELD DRIVE
CITY-ST-ZIP LONGWOOD FL

DELETE

TITLE TD
NAME LEVINE, GLORIA M
STREET ADDRESS 1856 WINGFIELD DRIVE
CITY-ST-ZIP LONGWOOD FL

DELETE

TITLE VD
NAME BRODSKY, NORMAN H.
STREET ADDRESS 1844 WINGFIELD DRIVE
CITY-ST-ZIP LONGWOOD FL

DELETE

TITLE SD
NAME BRODSKY, MAXINE N.
STREET ADDRESS 1844 WINGFIELD DRIVE
CITY-ST-ZIP LONGWOOD FL

DELETE

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP

DELETE

TITLE
NAME
STREET ADDRESS
CITY-ST-ZIP

DELETE

11 TITLE
12 NAME
13 STREET ADDRESS
14 CITY-ST-ZIP

Change Addition

21 TITLE
22 NAME
23 STREET ADDRESS
24 CITY-ST-ZIP

Change Addition

31 TITLE
32 NAME
33 STREET ADDRESS
34 CITY-ST-ZIP

Change Addition

41 TITLE
42 NAME
43 STREET ADDRESS
44 CITY-ST-ZIP

Change Addition

51 TITLE
52 NAME
53 STREET ADDRESS
54 CITY-ST-ZIP

Change Addition

61 TITLE
62 NAME
63 STREET ADDRESS
64 CITY-ST-ZIP

Change Addition

14. I do hereby certify that the information supplied with this filing is voluntarily furnished and does not qualify for the exemption stated in Section 119.07(3)(k), Florida Statutes. I further certify that the information included on this annual report or supplemental annual 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 617, Florida Statutes; and that my name appears in Block 12 or Block 13 if changed or on an attachment with an address.

SIGNATURE:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Norman H. Brodsky VP 7/27/96 574-1464

Date

Daytime Phone

CR2E034 (3/96)