

# 2006 FOR PROFIT CORPORATION ANNUAL REPORT

**FILED**  
**Mar 03, 2006 8:00 am**  
**Secretary of State**

2/5

02-09-2006 90031 017 \*\*\*150.00

<b>DOCUMENT # J07700</b> 1. Entry Name <b>AFFILIATED HEALTH PSYCHOLOGISTS, P.A.</b>					
<b>Aff. Health Psychologists</b> <b>6821 Southpoint Drive N.</b> <b>Suite 204</b> <b>Jacksonville, FL 32216</b>			<b>Aff. Health Psychologists</b> <b>6821 Southpoint Drive N.</b> <b>Suite 204</b> <b>Jacksonville, FL 32216</b>		
2. Principal Place of Business Suite, Apt. #, etc.			3. Mailing Address Suite, Apt. #, etc.		
City & State			City & State		
Zip		Country		4. FEI Number <b>59-2651126</b>	
5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required				Applied For <input type="checkbox"/> Not Applicable	
6. Name and Address of Current Registered Agent  <b>COLD, KATHLEEN H</b> <b>ONE INDEPENDENT DR.</b> <b>STE. 2301</b> <b>JACKSONVILLE, FL 32202</b>			7. Name and Address of New Registered Agent  Name Street Address (P.O. Box Number is Not Acceptable) City <b>FL</b> 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 re-registering) DATE _____					
<b>FILE NOW!!! FEE IS \$150.00</b> <b>After May 1, 2006 Fee will be \$550.00</b>			9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees		
10. OFFICERS AND DIRECTORS			11. OFFICERS AND DIRECTORS IN 11		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	PD KRIMSKY, EILEEN 14444 BEACH BLVD, SUITE 60 JACKSONVILLE, FL 32250	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	PD KRIMSKY, EILEEN Aff. Health Psychologists 6821 Southpoint Drive N. Suite 204 Jacksonville, FL 32216	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	VD MORELAND, JOHN 1444 BEACH BLVD, SUITE 60 JACKSONVILLE, FL	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	VD MORELAND, JOHN Aff. Health Psychologists 6821 Southpoint Drive N. Suite 204 Jacksonville, FL 32216	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition	<input type="checkbox"/> Change <input type="checkbox"/> Addition
12. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Chapter 119, 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:			020106 9042962900		
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR					



ATTACHMENT  
66003416

FLORIDA DEPARTMENT OF STATE  
Division of Corporations

February 10, 2006

AFFILIATED HEALTH PSYCHOLOGISTS, P.A.  
14444 BEACH BLVD  
SUITE 60  
JACKSONVILLE, FL 32250 US

Subject: **AFFILIATED HEALTH PSYCHOLOGISTS, P.A.**

Reference Number: **J07700**

Please be advised, we have received your annual report/uniform business report and your check(s) totaling \$150.00; however, the report **has not been filed** and a copy is being returned for the following correction(s):

*done* Provide the title(s) of each officer/director listed on the report or on an attachment.

After the corrections have been made, please return the report to: Division of Corporations, P.O. Box 1500, Tallahassee, Florida 32302-1500 within 30 days from the date of this letter.

If you have additional questions or need further assistance, please call the Division of Corporations at 850-245-6056 and press 4. Your call will be answered in the order it is received.

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ANNUAL REPORTS SECTION