

# 2006 NOT-FOR-PROFIT CORPORATION ANNUAL REPORT

**FILED**  
**Apr 06, 2006 8:00 am**  
**Secretary of State**

03-28-2006 90120 032 \*\*\*150.00

<b>DOCUMENT # N05000006364</b> 1. Entity Name <b>AMERICAN ACADEMY OF ORTHOPEDIC REGENERATIVE MEDICINE INC.</b>					
Principal Place of Business <b>9573 HARDING AVE MIAMI BEACH, FL 33154</b>			Mailing Address <b>9573 HARDING AVE MIAMI BEACH, FL 33154</b>		
2. Principal Place of Business		3. Mailing Address			
Suite, Apt. #, etc.		Suite, Apt. #, etc.			
City & State		City & State			
Zip	Country	Zip	Country		
6. Name and Address of Current Registered Agent				7. Name and Address of New Registered Agent	
OESTERLE, DOUGLAS W 9506 S RED RD MIAMI, FL 33156				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, type or print name of registered agent and state if applicable (NOTE: Registered Agent signature required when re-registering) DATE					
<b>Filing Fee is \$61.25 Due by May 1, 2006</b>		9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/>		<b>\$5.00 May Be Added to Fees</b>	
		<b>Make check payable to Florida Department of State</b>			
10. OFFICERS AND DIRECTORS			11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10		
TITLE	D <input type="checkbox"/> Delete		TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
NAME	FARSHCHIAN, ALEX		NAME		
STREET ADDRESS	9573 HARDING AVE		STREET ADDRESS		
CITY - ST - ZIP	MIAMI BEACH, FL 33154		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 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 617, 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 AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR					
Alimoraad Farshchian M.D.					

66008941



03222006 Chg-NP CR2E037 (11/05)

4. FEI Number **20-3027955** Applied For ☐ Not Applicable ☒

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

FL Zip Code

4-3-06