

2001 UNIFORM BUSINESS REPORT (UBR)

FILED
Apr 17, 2001 8:00 am
Secretary of State

0040124

04-17-2001 90176 045 ****61.25

DOCUMENT # N99000005507

1. Entity Name

COALITION OF CLINICAL PRACTITIONERS OF NEUROPSYC

00047256



DO NOT WRITE IN THIS SPACE

Principal Place of Business 7800 RED ROAD SUITE 310 MIAMI FL 33143	Mailing Address 7800 RED ROAD SUITE 310 MIAMI FL 33143
--	--

2. Principal Place of Business Suite, Apt. #, etc.	3. Mailing Address Suite, Apt. #, etc.
City & State	City & State
Zip Country	Zip Country

4. FEI Number 65-0950874	Applied For <input type="checkbox"/> Not Applicable
5. Certificate of Status Desired <input type="checkbox"/>	\$8.75 Additional Fee Required

6. Name and Address of Current Registered Agent CROWN, BARRY PH.D. 7800 RED ROAD SUITE 310 MIAMI FL 33143	7. Name and Address of New Registered Agent 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 _____ DATE _____
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)

FILE NOW: FEE IS \$61.25	9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees	Make Check Payable to Department of State
-------------------------------------	---	--

10. OFFICERS AND DIRECTORS		11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	PD HOM, JIM PH.D. 9400 N. CENTRAL EXP., STE 904 DALLAS TX 75231 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	T CROWN, BARRY PH.D. 7800 RED RD., STE 310 MIAMI FL 33143 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	SD HORTON, JR., ARTHUR M ED.D. 5903 LONE OAK DR. BETHESDA MD 20814 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition

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 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]* **BARRY CROWN** **TREASURER** **4/13/01** **305 665-0771**
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CR2E037 (10/00)