
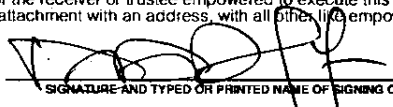


2005 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Mar 28, 2005 8:00 am
Secretary of State

03-28-2005 90076 046 ***150.00

| | | | | | |
|---|--|--|--|---|--|
| DOCUMENT # P97000100890 1. Entity Name BOCA SPINE & REHABILITATION CENTER, INC. | | | |  | |
| Principal Place of Business 101 S CONGRESS AVE SUITE I DELRAY BEACH, FL 33445 | | | Mailing Address 5884 MICHAUX STREET BOCA RATON, FL 33433 | | |
| 2. Principal Place of Business 5884 MICHAUX STREET | | 3. Mailing Address | | | |
| Suite, Apt. #, etc. | | Suite, Apt. #, etc. | | | |
| City & State BOCA RATON, FLORIDA | | City & State | | 4. FEI Number 65-0801134 | |
| Zip 33433 | | Country USA | | 5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required | |
| 6. Name and Address of Current Registered Agent DICRISTOFARO, DANIEL DR. 5884 MICHAUX STREET BOCA RATON, FL 33433 | | | 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. I am familiar with, and accept the obligations of registered agent. SIGNATURE _____ DATE _____ <small>Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)</small> | | | | | |
| FILE NOW!!! FEE IS \$150.00 After May 1, 2005 Fee will be \$550.00 | | 9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees | | | |
| 10. OFFICERS AND DIRECTORS | | | 11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11 | | |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | D APPLETON, PHILLY 1215 SW 26TH AVE POMPANO BEACH, FL 33069 | <input type="checkbox"/> Delete | | | |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | D DICRISTOFARO, DANIEL 5884 MICHAUX STREET BOCA RATON, FL 33433 | <input type="checkbox"/> Delete | | | |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | | <input type="checkbox"/> Delete | | | |
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| TITLE NAME STREET ADDRESS CITY-ST-ZIP | | <input type="checkbox"/> Delete | | | |
| 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:  DR. DANIEL DICRISTOFARO 3/23/05 561 274-7973 <small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #</small> | | | | | |