


2006 FOR PROFIT CORPORATION ANNUAL REPORT (AR)

FILED
Mar 06, 2006 08:00 AM
Secretary of State

DOCUMENT # 493324					
1. Entity Name MICHAEL D. KOHEN, M.D., P.A.					
Principal Place of Business 709 NORTH CLYDE MORRIS BLVD. DAYTONA BCH. FL 32114			Mailing Address 709 NORTH CLYDE MORRIS BLVD. DAYTONA BCH. FL 32114		
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 59-1641576	
5. Certificate of Status Desired <input type="checkbox"/>				Applied For Not Applicable	
6. Name and Address of Current Registered Agent KOHEN M.D., MICHAEL D. 709 NORTH CLYDE MORRIS BLVD. DAYTONA BEACH FL 32114				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 _____ (NOTE: Registered Agent signature required when reinstating) DATE _____					
FILE NOW!!! FEE IS \$150.00 After May 1, 2006 Fee Will Be \$550.00 Make Check Payable to Florida Department of State				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	PD <input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition		
NAME	KOHEN M.D., MICHAEL D.	NAME	000000454488		
STREET ADDRESS	709 N CLYDE MORRIS BLVD	STREET ADDRESS	03/18/06-80035-009 150.00		
CITY-ST-ZIP	DAYTONA BEACH FL	CITY-ST-ZIP			
TITLE	S <input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition		
NAME	DIAMOND, MICHAEL A., M.D	NAME			
STREET ADDRESS	709 N CLYDE MORRIS BLVD	STREET ADDRESS			
CITY-ST-ZIP	DAYTONA BEACH FL	CITY-ST-ZIP			
TITLE	V <input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition		
NAME	TSAL, YONG H M.D.	NAME			
STREET ADDRESS	1200 WEST GRANADA BOULEVARD SUITE 6	STREET ADDRESS			
CITY-ST-ZIP	ORMOND BEACH FL 32174	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 Section 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: Michael D. Kohen **MICHAEL D. KOHEN** **31-06 3862521632**