

# 2003 NOT-FOR-PROFIT CORPORATION UNIFORM BUSINESS REPORT (UBR)

**FILED**  
**Feb 21, 2003 8:00 am**  
**Secretary of State**

02-21-2003 90854 050 \*\*\*\*70.00

**DOCUMENT # F01000001749**

1. Entity Name  
**NEURAL ENGINEERING CLINIC, INC.**



Principal Place of Business  
**330 HAMMOCK SHORE DRIVE  
MELBOURNE BEACH FL 32951**

Mailing Address  
**330 HAMMOCK SHORE DRIVE  
MELBOURNE BEACH FL 32951**

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Zip

Country

Zip

Country

4. FEI Number **01-0494502**

Applied For

Not Applicable

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

☐ CHECK HERE IF MAKING CHANGES



6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

**DAVIS, ROSS M.D.  
330 HAMMOCK SHORE DRIVE  
MELBOURNE BEACH FL 32951**

Name **Davis, Ross M.D.**  
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, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE

**FILE NOW: FEE IS \$61.25**

9. Election Campaign Financing  
Trust Fund Contribution. ☐

**\$5.00** May Be  
Added to Fees

**Make Check Payable to  
Florida Department of State**

10. OFFICERS AND DIRECTORS

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10

TITLE  
NAME **PCD**  
STREET ADDRESS **DAVIS, ROSS M.D.**  
CITY-ST-ZIP **330 HAMMOCK SHORE DRIVE  
MELBOURNE BEACH FL 32951**

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Change ☐ Addition

TITLE  
NAME **STD**  
STREET ADDRESS **EMMONS, SANDRA**  
CITY-ST-ZIP **76 EASTERN AVE.  
AUGUSTA ME 04330**

TITLE  
NAME **STD**  
STREET ADDRESS **Emmons, Sandra**  
CITY-ST-ZIP **R1 #685,  
Richmond, ME, 04357** ☒ Change ☐ Addition

TITLE  
NAME **D**  
STREET ADDRESS **MCKENDRY, JAMES M.D.**  
CITY-ST-ZIP **P.O. BOX 264  
MANCHESTER ME 04351**

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Change ☐ Addition

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Delete

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Change ☐ Addition

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Delete

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Change ☐ Addition

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Delete

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP ☐ Change ☐ 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 REQUIRED (ROSS DAVIS)** 2/17/03 (320) 733-6580

CR2E037 (10/02)