


**2004 NOT-FOR-PROFIT CORPORATION
ANNUAL REPORT (AR)**

FILED
Jul 30, 2004 8:00 am
Secretary of State

07-30-2004 90007 017 ****61.25

DOCUMENT # F02000002358

1. Entity Name
THE INSTITUTE OF ALLIED MEDICAL PROFESSIONS, CORPORATION



Principal Place of Business
**405 PARK AVENUE, SUITE 501
NEW YORK NY 10022**

Mailing Address
**405 PARK AVENUE, SUITE 501
NEW YORK NY 10022**

44050884



MOORE CR2E037 (4/04)

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

3. Mailing Address
Suite, Apt. #, etc.
City & State
Zip Country

4. FEI Number
13-2928042

Applied For
 Not Applicable

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

6. Name and Address of Current Registered Agent
**MASTEN, KERRY
927 45TH STREET
WEST PALM BEACH FL 33407**

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 _____
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
Due By September 8, 2004**

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

TITLE NAME STREET ADDRESS CITY-ST-ZIP	PCT HAGGERTY, THOMAS 286 HARBOR DRIVE LIDO BEACH NY 11561	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D HUGHES, JUDY 110 POPPY AVE FRANKLIN SQUARE NY	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	S HAGGERTY, JAMIE 286 HARBOR DRIVE LIDO BEACH FL 11561	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	VC BELL, ANNEMARIE 48 TURKEY HILL ROAD NEWBURYPORT MA	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	DOA HAGGORTY, BRIAN 12 HUBER CT ROCKVILLE CENTRE NY 11570	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D BAER, NANCY 65-61 PARSONS BLVD. FLUSHING NY 11365	<input type="checkbox"/> Delete

11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10

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"/> Change <input type="checkbox"/> Addition
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"/> Change <input type="checkbox"/> Addition
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"/> 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 officers empowered.

SIGNATURE: _____ DATE: **7/26/04** DAYTIME PHONE #: **212-258-1411**
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR