

**2005 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED
Apr 29, 2005 08:00 AM
Secretary of State

DOCUMENT # G58554	
1. Entity Name CHIROPRACTIC BACK PAIN CLINIC INC.	

Principal Place of Business 2645 DOUGLAS RD STE 704 MIAMI, FL 33133	Mailing Address 2645 DOUGLAS RD STE 704 MIAMI, FL 33133
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DO NOT WRITE IN THIS SPACE

01282005 No Chg-P CR2E034 (10/03)

4. FEI Number 59-2324477	Applied For ☐ Not Applicable
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5. Certificate of Status Desired ☐	\$8.75 Additional Fee Required
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6. Name and Address of Current Registered Agent FERNANDEZ, OCTAVIO P D.C. 2645 DOUGLAS RD STE 704 MIAMI, FL 33133

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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.

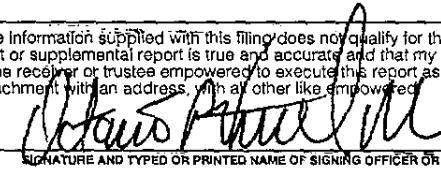
SIGNATURE _____ (NOTE: Registered Agent signature required when reinstating) DATE _____

FILE NOW!!! FEE IS \$150.00 After May 1, 2005 Fee will be \$550.00	9. Election Campaign Financing Trust Fund Contribution ☐ \$5.00 May Be Added to Fees
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10. OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY - ST - ZIP	PSD FERNANDEZ, OCTAVIO P D.C. 2645 DOUGLAS RD #704 MIAMI, FL 33133
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U000000341672 04/29/05-80025-022 150.00
DO NOT WRITE IN THIS SPACE

12. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(f), 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:  **Octavio P. Fernandez** 4127105 307741119
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #