2004 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Mar 12, 2004 08:00 AM
Secretary of ~~State~~

DOCUMENT # K43086

1. Entity Name
THE PROGRAM WORKSHOP, INC.

Principal Place of Business	Mailing Address
301 HEALTHPARK BLVD 328 SAINT AUGUSTINE, FL 32086	301 HEALTHPARK BLVD 328 SAINT AUGUSTINE, FL 32086

DO NOT WRITE IN THIS SPACE

03102004 No Chg-P CR2E034 (10/03)

4. FEI Number 54-1310979 ☐ Applied For ☐ Not Applicable

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

6. Name and Address of Current Registered Agent

SANDERS, MICHAEL D MD
301 HEALTH PARK BLVD
328
SAINT AUGUSTINE, FL 32086

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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 _____ DATE
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)

FILE NOW!!! FEE IS $150.00
After May 1, 2004 Fee will be $550.00

9. Election Campaign Financing Trust Fund Contribution. ☐ **$5.00** May Be Added to Fees

10. OFFICERS AND DIRECTORS

TITLE	D
NAME	SANDERS, MICHAEL C., MD
STREET ADDRESS	301 HEALTH PARK BLVD.
CITY-ST-ZIP	ST. AUGUSTINE, FL
TITLE	D
NAME	SANDERS, MARYANNE J.
STREET ADDRESS	301 HEALTH PARK BLVD.
CITY-ST-ZIP	ST. AUGUSTINE, FL
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
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TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	

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03/12/04-80025-006 150.00

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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: Michael Sanders MICHAEL SANDERS, MD 3-10-04 904 829 650.
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #