

**2005 FOR PROFIT CORPORATION  
ANNUAL REPORT**

**FILED**  
**Feb 02, 2005 08:00 AM**  
**Secretary of State**

**DOCUMENT # K43086**

1. Entity Name  
**THE PROGRAM WORKSHOP, INC.**



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

Mailing Address  
**301 HEALTHPARK BLVD  
328  
SAINT AUGUSTINE, FL 32086**



01192005 No Chg-P CR2E034 (10/03)

**DO NOT WRITE IN THIS SPACE**

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**

**DO NOT WRITE  
IN THIS SPACE**

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)

**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**

DATE **02/02/05-80079-009 150.00**

**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	
TITLE	
NAME	
STREET ADDRESS	
CITY - ST - ZIP	
TITLE	
NAME	
STREET ADDRESS	
CITY - ST - ZIP	

**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)(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 MD* **PRESIDENT** **MICHAEL SANDERS, MD** **02/02/05** **904-824-6500**  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #