


2006 FOR PROFIT CORPORATION - ANNUAL REPORT

FILED
Jan 27, 2006 08:00 AM
Secretary of State

DOCUMENT # K43086 1. Entity Name THE PROGRAM WORKSHOP, INC.	
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Principal Place of Business 301 HEALTHPARK BLVD 328 SAINT AUGUSTINE, FL 32086	Mailing Address 301 HEALTHPARK BLVD 328 SAINT AUGUSTINE, FL 32086
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DO NOT WRITE IN THIS SPACE



01132006 No Chg-P CR2E034 (11/05)

4. FEI Number 54-1310979	Applied For Not Applicable
5. Certificate of Status Desired <input type="checkbox"/>	\$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 _____ (NOTE: Registered Agent signature required when reinstating) DATE _____

FILE NOW!!! FEE IS \$150.00
After May 1, 2006 Fee will be \$550.00

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

000000402478
02/03/06-80009-021 150.00

10. OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY - ST - ZIP	D SANDERS, MICHAEL C., MD 301 HEALTH PARK BLVD. ST. AUGUSTINE, FL
TITLE NAME STREET ADDRESS CITY - ST - ZIP	D SANDERS, MARYANNE J. 301 HEALTH PARK BLVD. ST. AUGUSTINE, FL
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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 exemptions contained in Chapter 119, 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 1-24-06 904-825-3616

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #