


**2005 NOT-FOR-PROFIT CORPORATION
ANNUAL REPORT (AR)**

**FILED
Mar 30, 2005 08:00 AM
Secretary of State**

DOCUMENT # N19003					
1. Entity Name FLORIDA NETWORK OF NEUROGENIC COMMUNICATION DISORDERS, INC.					
Principal Place of Business 3709 W. HAMILTON AVE. SUITE 2 TAMPA FL 33614-4015			Mailing Address 3709 W. HAMILTON AVE SUITE 2 TAMPA FL 33614-4015		
2. Principal Place of Business		3. Mailing Address			
Suite, Apt #, etc.		Suite, Apt. #, etc.			
City & State		City & State		4. FEI Number 59-2770518	
Zip		Country		5. Certificate of Status Desired <input checked="" type="checkbox"/> \$8.75 Additional Fee Required	
6. Name and Address of Current Registered Agent BARTH, JEANNE M 3709 W. HAMILTON AVE STE. 2 TAMPA FL 33614-4015			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 _____ (NOTE: Registered Agent signature required when reinstating) _____ DATE _____					
FILE NOW: FEE IS \$61.25 Due By May 1, 2005		9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/>		\$5.00 May Be Added to Fees	
Make Check Payable to Florida Department of State					
10. OFFICERS AND DIRECTORS			11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 10		
TITLE	D <input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition		
NAME	HALL, BETH	NAME			
STREET ADDRESS	6094 GLENDALE DRIVE	STREET ADDRESS			
CITY-ST-ZIP	BOCA RATON FL 33433	CITY-ST-ZIP		U00000281207 03/30/05-80050-011 79.00	
TITLE	D <input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition		
NAME	BARTH, JEANNE M	NAME			
STREET ADDRESS	3709 W. HAMILTON AVE STE. 2	STREET ADDRESS			
CITY-ST-ZIP	TAMPA FL 33614-4015	CITY-ST-ZIP			
TITLE	D <input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition		
NAME	KRAMER, CHERYL	NAME			
STREET ADDRESS	129 VIA HAVARRE	STREET ADDRESS			
CITY-ST-ZIP	MERRITT ISLAND FL 34953	CITY-ST-ZIP			
TITLE	D <input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition		
NAME	SHYLAK, JODI	NAME			
STREET ADDRESS	1500 PALM BEACH ROAD	STREET ADDRESS			
CITY-ST-ZIP	STUART FL 34994	CITY-ST-ZIP			
TITLE	D <input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition		
NAME	COHEN, GAYLE	NAME			
STREET ADDRESS	4105 N. 49TH AVENUE	STREET ADDRESS			
CITY-ST-ZIP	HOLLYWOOD FL 33021	CITY-ST-ZIP			
TITLE	<input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition		
NAME		NAME			
STREET ADDRESS		STREET ADDRESS			
CITY-ST-ZIP		CITY-ST-ZIP			
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 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 like empowered.					
SIGNATURE: <i>Jeanne Barth</i>			Date: <i>3/26/05</i> 813-930-0187		
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR			Daytime Phone #		