


**2004 NOT-FOR-PROFIT CORPORATION  
ANNUAL REPORT**

**FILED**  
**Feb 23, 2004 08:00 AM**  
**Secretary of State**

<b>DOCUMENT # N96000001358</b> 1. Entity Name <b>CHIROPRACTIC CARE INDEPENDENT PRACTICE ASSOCIATION, INC.</b>	
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Principal Place of Business <b>9770 OLD BAYMEADOWS ROAD SUITE 139 JACKSONVILLE, FL 32256</b>	Mailing Address <b>9770 OLD BAYMEADOWS ROAD SUITE 139 JACKSONVILLE, FL 32256</b>
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02172004 No Chg-NP CR2E037 (10/03)

4. FEI Number <b>59-3518612</b>	Applied For <input type="checkbox"/> Not Applicable
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5. Certificate of Status Desired <input type="checkbox"/>	<b>\$8.75 Additional Fee Required</b>
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**DO NOT WRITE IN THIS SPACE**

6. Name and Address of Current Registered Agent  <b>ALTOMARE, JOSEPH J 9770 OLD BAYMEADOWS ROAD SUITE 139 JACKSONVILLE, FL 32256</b>
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**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 \_\_\_\_\_  
Signature, typed or printed name of registered agent and title if applicable.

**Filing Fee is \$61.25  
Due by May 1, 2004**

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

**10. OFFICERS AND DIRECTORS**

TITLE NAME STREET ADDRESS CITY - ST - ZIP	D ALTOMARE, JOSEPH J DC 9770 OLD BAYMEADOWS RD, #139 JACKSONVILLE, FL 32256
TITLE NAME STREET ADDRESS CITY - ST - ZIP	D FIORE, MICHAEL DC 8101-5 SOUTHSIDE BLVD JACKSONVILLE, FL 32256
TITLE NAME STREET ADDRESS CITY - ST - ZIP	D JOHNSON, ALAN DC 703 SOUTH MYRTLE AVE CLEARWATER, FL 33516
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 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:**   
Signature, typed or printed name of signing officer or director

**2-19-04**  
Date

**904-641-1134**  
Daytime Phone #