

**2005 FOR PROFIT CORPORATION
AMENDED ANNUAL REPORT**


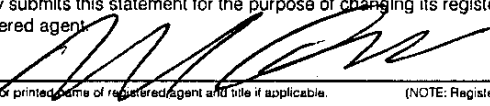
Amended

FILED

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SECRETARY OF STATE
TALLAHASSEE, FLORIDA



DOCUMENT # P02000116537			
1. Entity Name THE NATURAL MEDICINE AND WELLNESS CENTER OF FLORIDA, INC.			
Principal Place of Business 5150 BELFORT ROAD BUILDING 400 JACKSONVILLE, FL 32256 US		Mailing Address 5150 BELFORT ROAD BUILDING 400 JACKSONVILLE, FL 32256 US	
2. Principal Place of Business 4237 SALISBURY ROAD Suite, Apt. #, etc. SUITE 110 City & State JACKSONVILLE, FL Zip 32216		3. Mailing Address 4237 SALISBURY ROAD Suite, Apt. #, etc. SUITE 110 City & State JACKSONVILLE, FL Zip 32216	
6. Name and Address of Current Registered Agent COHEN, NORMAN S M.D. 5150 BELFORT ROAD BUILDING 400 JACKSONVILLE, FL 32256		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 		DATE 3-14-05	
Amended AR is \$61.25		9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees	
10. OFFICERS AND DIRECTORS		11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	PDVT COHEN, NORMAN S M.D. <input type="checkbox"/> Delete 5150 BELFORT ROAD, BUILDING 400 JACKSONVILLE, FL 32256	TITLE NAME STREET ADDRESS CITY-ST-ZIP	PDT <input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition COHEN, NORMAN S., M.D. 5150 BELFORT ROAD, BUILDING 400 JACKSONVILLE, FL 32256
TITLE NAME STREET ADDRESS CITY-ST-ZIP	S <input type="checkbox"/> Delete COHEN, NORMAN S M.D. 5150 BELFORT ROAD, BUILDING 400 JACKSONVILLE, FL 32256	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition 200049078362 03/24/05--01010--013 **\$61.25
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	VD <input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition GRABLE, STEPHEN E., M.D. 1504 ROBERTS DRIVE JACKSONVILLE BEACH, FL 32250
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition

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:  DATE 3-14-05

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