


2006 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
May 11, 2006 8:00 am
Secretary of State

05-11-2006 90238 047 ***150.00

DOCUMENT # P04000096737					
1. Entity Name PHYSICIANS THERAPY CLINIC OF TAMPA, INC.					
Principal Place of Business 4601 W. KENNEDY BLVD. 102 TAMPA, FL 33609 US			Mailing Address PO BOX 8747 TAMPA, FL 33674-8747 US		
2. Principal Place of Business		3. Mailing Address		04272006 Chg-P CR2E034 (11/05)	
Suite, Apt. #, etc.		Suite, Apt. #, etc.		4. FEI Number 20-1287648	
City & State		City & State		Applied For Not Applicable	
Zip	Country	Zip	Country	5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required	
6. Name and Address of Current Registered Agent				7. Name and Address of New Registered Agent	
DUNCAN, ANGELA 4601 W. KENNEDY BLVD. 102 TAMPA, FL 33609				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 \$150.00 After May 1, 2006 Fee will be \$550.00			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	P ANGELA, DUNCAN 4601 W. KENNEDY BLVD, #102 TAMPA, FL 33609 <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	
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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: _____			Date _____ Daytime Phone # _____		
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR					