


2005 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Apr 27, 2005 8:00 am
Secretary of State

04-27-2005 90311 004 ***150.00

DOCUMENT # P04000154426			
1. Entity Name ACCIDENT CARE & WELLNESS CHIROPRACTIC CLINIC, INC.			
Principal Place of Business 5913 NORMANDY BLVD. 13 JACKSONVILLE, FL 32205		Mailing Address 5913 NORMANDY BLVD. 13 JACKSONVILLE, FL 32205	
2. Principal Place of Business		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country
6. Name and Address of Current Registered Agent		7. Name and Address of New Registered Agent	
PATEL, VIPUL R 5924 COVERED CREEK LANE JACKSONVILLE, FL 32277		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 _____ <small>Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)</small>			
FILE NOW!!! FEE IS \$150.00 After May 1, 2005 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	P/T <input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	PATEL, VIPUL R	NAME	
STREET ADDRESS	5924 COVERED CREEK LANE	STREET ADDRESS	
CITY-ST-ZIP	JACKSONVILLE, FL 32277	CITY-ST-ZIP	
TITLE	VS <input type="checkbox"/> Delete	TITLE	<input type="checkbox"/> Change <input type="checkbox"/> Addition
NAME	ALBERT, GEORGE L	NAME	
STREET ADDRESS	5365 OAK BAY DR.	STREET ADDRESS	
CITY-ST-ZIP	JACKSONVILLE, FL 32205	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	
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	
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)(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: 4/13/05 Daytime Phone #: 904-743-2222	
<small>SIGNATURE AND TYPED OR PRINTED NAME OF REGISTERED OFFICER OR DIRECTOR</small>		<small>Date Daytime Phone #</small>	