
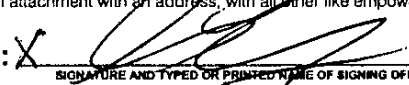


2007 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
May 02, 2007 08:00 AM
Secretary of State

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 - No P.O. Box #		3. Mailing Address			
Suite, Apt. #, etc.		Suite, Apt. #, etc.			
City & State		City & State		4. FEI Number 20-1912343	
Zip		Country		5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required	
6. Name and Address of Current Registered Agent PATEL, VIPUL R 5924 COVERED CREEK LANE JACKSONVILLE, FL 32277			7. Name and Address of New Registered Agent		
Name			Street Address (P.O. Box Number is Not Acceptable)		
City			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, 2007 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	U00000754562	
STREET ADDRESS	5924 COVERED CREEK LANE		STREET ADDRESS	05/22/07-80065-022 150.00	
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 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: 4/10/07		Daytime Phone #: 904-237-5239
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR					