

# 2010 FOR PROFIT CORPORATION ANNUAL REPORT

DOCUMENT# P04000159764

FILED  
Apr 09, 2010  
Secretary of State

**Entity Name:** INSTITUTE OF ALLIED MEDICAL PROFESSIONS, INC.

**Current Principal Place of Business:**

5150 LINTON BOULEVARD  
SUITE 340  
DELRAY BEACH, FL 33484

**New Principal Place of Business:**

**Current Mailing Address:**

405 PARK AVE.  
SUITE 501  
NEW YORK, NY 10022

**New Mailing Address:**

**FEI Number:** 20-2058034

**FEI Number Applied For ( )**

**FEI Number Not Applicable ( )**

**Certificate of Status Desired ( )**

**Name and Address of Current Registered Agent:**

VIDAL, KARYN  
2269 RIDGEWOOD CIRCLE  
ROYAL PALM BEACH, FL 33411 US

**Name and Address of New Registered Agent:**

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.

SIGNATURE:

\_\_\_\_\_  
Electronic Signature of Registered Agent

\_\_\_\_\_  
Date

**Election Campaign Financing Trust Fund Contribution ( ).**

**OFFICERS AND DIRECTORS:**

Title: D  
Name: HAGGERTY, THOMAS  
Address: 405 PARK AVE, SUITE 501  
City-St-Zip: NEW YORK, NY 10022

Title: D  
Name: HAGGERTY, JAMIE  
Address: 405 PARK AVE  
City-St-Zip: NEW YORK, NY 10022

Title: D  
Name: HAGGERTY, BRIAN  
Address: 405 PARK AVE  
City-St-Zip: NEW YORK, NY 10022

Title: D  
Name: HAGGERTY, KEVIN  
Address: 405 PARK AVE  
City-St-Zip: NEW YORK, NY 10022

I hereby certify that the information indicated on this report or supplemental report is true and accurate and that my electronic 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 above, or on an attachment with all other like empowered.

SIGNATURE: THOMAS HAGGERTY

PRES

04/09/2010

\_\_\_\_\_  
Electronic Signature of Signing Officer or Director

\_\_\_\_\_  
Date