

**2006 FOR PROFIT CORPORATION
ANNUAL REPORT**

DOCUMENT # P05000142829

1. Entity Name
CONDE CENTER FOR CHIROPRACTIC NEUROLOGY
INC.



Principal Place of Business
16279 SIERRA PALMS DRIVE
DELRAY BEACH, FL 33484

Mailing Address
16279 SIERRA PALMS DRIVE
DELRAY BEACH, FL 33484

2. Principal Place of Business
401 W. Atlantic Ave.
Suite, Apt. #, etc.
#014

3. Mailing Address
401 W. Atlantic Ave.
Suite, Apt. #, etc.
#014

City & State
Delray Beach, FL
Zip 33488

City & State
Delray Beach, FL
Zip 33488

6. Name and Address of Current Registered Agent

CONDE, JUAN
16279 SIERRA PALMS DRIVE
DELRAY BEACH, FL 33484

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

Signature, typed or printed name of registered agent and title if applicable.

(NOTE: Registered Agent signature required when nonstating)

DATE

**FILE NOW!! FEE IS \$150.00
After May 1, 2006 Fee will be \$550.00**

9. Election Campaign Financing
Trust Fund Contribution.

\$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	DIR CONDE, JUAN 16279 SIERRA PALMS DRIVE DELRAY BEACH, FL 33484	<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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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 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 empowerments.

SIGNATURE:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

**FILED
May 08, 2006 8:00 am
Secretary of State**

05-08-2006 90295 041 ***150.00

