
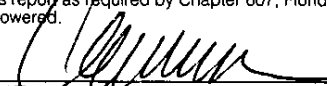


2008 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Apr 11, 2008 8:00 am
Secretary of State

04-11-2008 90064 029 ***150.00

DOCUMENT # P07000087838 1. Entity Name NEUROLOGY SOLUTIONS, P.A.					
Principal Place of Business 285 KATRINA STREET DELEON SPRINGS, FL 32130			Mailing Address 285 KATRINA STREET DELEON SPRINGS, FL 32130		
2. Principal Place of Business - No P.O. Box #		3. Mailing Address P.O. BOX 249			
Suite, Apt. #, etc.		Suite, Apt. #, etc.			
City & State		City & State DeLand FL		4. FEI Number 51-0648011	
Zip		Country		5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required	
32721		Volusia		02132008 Chg-P CR2E034 (12/06)	
6. Name and Address of Current Registered Agent CARINCI, STEPHANIE MD 285 KATRINA STREET DELEON SPRINGS, FL 32130				7. Name and Address of New Registered Agent 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 _____ <small>Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE</small>					
FILE NOW!!! FEE IS \$150.00 After May 1, 2008 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	D CARINCI, STEPHANIE MD 285 KATRINA STREET DELEON SPRINGS, FL 32130	<input type="checkbox"/> Delete			
TITLE NAME STREET ADDRESS CITY-ST-ZIP	ST John R McCormick, MD 285 Katrina St DeLeon Springs, FL, 32130	<input type="checkbox"/> Delete			
TITLE NAME STREET ADDRESS CITY-ST-ZIP	(Empty)	<input type="checkbox"/> Delete			
TITLE NAME STREET ADDRESS CITY-ST-ZIP	(Empty)	<input type="checkbox"/> Delete			
TITLE NAME STREET ADDRESS CITY-ST-ZIP	(Empty)	<input type="checkbox"/> Delete			
TITLE NAME STREET ADDRESS CITY-ST-ZIP	(Empty)	<input type="checkbox"/> Delete			
TITLE NAME STREET ADDRESS CITY-ST-ZIP	(Empty)	<input type="checkbox"/> Delete			
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: Stephanie Carinci MD  4/9/08 386-736-8622 <small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #</small>					