2008 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Apr 11, 2008 8:00 am
Secretary of State
04-11-2008 90064 029 ***150.00

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1. Entity Name
NEUROLOGY SOLUTIONS, P.A.

Principal Place of Business	Mailing Address
285 KATRINA STREET DELEON SPRINGS, FL 32130	285 KATRINA STREET DELEON SPRINGS, FL 32130

02132008 Chg-P CR2E034 (12/06)

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	
Zip	Country	Zip: 32721	Country: Volusia

4. FEI Number: 51-0648011 ☐ Applied For ☐ Not Applicable

5. Certificate of Status Desired ☐ **$8.75** Additional Fee Required

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 ______________________
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE

FILE NOW!!! FEE IS $150.00
After May 1, 2008 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	D CARINCI, STEPHANIE MD 285 KATRINA STREET DELEON SPRINGS, FL 32130	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	ST John R McCormick,MD 285 Katrina St DeLeon Springs, FL, 32130	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ Addition
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TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP		☐ Change ☐ 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 empowered.

SIGNATURE: Stephanie Carinci MD [signature] 4/9/08 386-736-8622
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #