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Apr 24 1997 8:00am
Secretary of State

PROFIT
CORPORATION
ANNUAL REPORT
1997



FLORIDA DEPARTMENT OF STATE
Sandra B. Mortham
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # P39940 (2)

1. Corporation Name

HEALTHCARE STAFFING SOLUTIONS, INC.

Principal Place of Business

Mailing Address

800 CHELMSFORD STREET
CROSS POINT TOWER II 8TH FLOOR
LOWELL MA 01851
US

800 CHELMSFORD STREET
CROSS POINT TOWER II 8TH FLOOR
LOWELL MA 01851-5151
US



3. Date Incorporated or Qualified

08/05/1992

3a. Date of Last Report

04/16/1996

4. FEI Number

04-3063643

Applied For

Not Applicable

5. Certificate of Status Desired

☐

\$8.75 Additional
Fee Required

6. Election Campaign Financing
Trust Fund Contribution

☐

\$5.00 May Be
Added to Fees

8. This corporation has liability for intangible tax under s. 199.032,
Florida Statutes

☐

Yes

☐

No

2. Principal Place of Business

2a. Mailing Address

21 Suite, Apt. #, etc.

26 Suite, Apt. #, etc.

22 City & State

27 City & State

23 Zip

25 Country

28 Zip

30 Country

9. Name and Address of Current Registered Agent

THE PRENTICE-HALL CORPORATION SYSTEM INC.
1201 HAYS STREET
SUITE 105
TALLAHASSEE FL 32301

10. Name and Address of New Registered Agent

81 Name

82 Street Address (P.O. Box Number is Not Acceptable)

83

84 City

FL

85 Zip Code

11. Pursuant to the provisions of Sections 607.0502 and 607.1508, Florida Statutes, the above-named corporation submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with, and accept the obligations of, Section 607.0505, Florida Statutes.

SIGNATURE

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

(NOTE: Registered Agent signature required when reinstating)

DATE

12. OFFICERS AND DIRECTORS

13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12

TITLE	NAME	STREET ADDRESS	CITY-ST-ZIP	DELETE
DVP	CIKACZ, MICHAEL	67 CRANBERRY LANE	N ANDOVER MA	<input type="checkbox"/>
DP	STODDARD, RICHARD C.	125 CAMPION WAY	N ANDOVER MA	<input type="checkbox"/>
DC	USDAN, JAMES M.	7733 FORSYTH BLVD SUITE 1700	ST. LOUIS MO	<input type="checkbox"/>
T	RANELLI, PAUL D.	8 HOLLY GATE CIRCLE	MIDDLETOWN MA	<input type="checkbox"/>
SD	HENDERSON, ALAN C.	7733 FORSYTH BLVD SUITE 1700	ST. LOUIS MO	<input type="checkbox"/>
AT	FINKENKELLER, JOHN R.	7733 FORSYTH BLVD	ST. LOUIS MO	<input type="checkbox"/>

1.1 TITLE	1.2 NAME	1.3 STREET ADDRESS	1.4 CITY-ST-ZIP	Change	Addition
2.1 TITLE	2.2 NAME	2.3 STREET ADDRESS	2.4 CITY-ST-ZIP	<input type="checkbox"/>	<input type="checkbox"/>
3.1 TITLE	3.2 NAME	3.3 STREET ADDRESS	3.4 CITY-ST-ZIP	<input type="checkbox"/>	<input type="checkbox"/>
4.1 TITLE	4.2 NAME	4.3 STREET ADDRESS	4.4 CITY-ST-ZIP	<input type="checkbox"/>	<input type="checkbox"/>
5.1 TITLE	5.2 NAME	5.3 STREET ADDRESS	5.4 CITY-ST-ZIP	<input type="checkbox"/>	<input type="checkbox"/>
6.1 TITLE	6.2 NAME	6.3 STREET ADDRESS	6.4 CITY-ST-ZIP	<input type="checkbox"/>	<input type="checkbox"/>

14. I do hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(i), Florida Statutes. I further certify that the information indicated on this annual report or supplemental annual 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 12 or Block 13 if changed, or on an attachment with an address.

SIGNATURE:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

4-14-97

508 531 4000

Date

Daytime Phone #

CR2E034 (9/96)

**HEALTHCARE STAFFING SOLUTIONS, INC.
900 CHELMSFORD STREET
SUITE 208
LOWELL, MA 01851**

ADDITIONAL DIRECTOR

STEPHEN J. TOTH

**1835 ELMSFORD LANE
CHESTERFIELD, MO 63005**