

2004 FOR PROFIT CORPORATION ANNUAL REPORT

07-16-2004 90004 014 ***150.00
P92000011364

DOCUMENT # P92000011364

1. Entity Name
NEURO-MYOLOGY THERAPY, INC.



FILED

04 JUL 23 AM 10:26

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

Principal Place of Business
2030-A WASHINGTON STREET
HOLLYWOOD, FL 33020

Mailing Address
2030-A WASHINGTON STREET
HOLLYWOOD, FL 33020



07022004 No Chg-P CR2E034 (10/03)

DO NOT WRITE IN THIS SPACE

4. FEI Number
65-0373905
Applied For
Not Applicable
5. Certificate of Status Desired ☐ \$8.75 Additional
Fee Required

6. Name and Address of Current Registered Agent

FOSTER, SCOTT S
2030-A WASHINGTON STREET
HOLLYWOOD, FL 33020

**DO NOT WRITE
IN THIS SPACE**

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] (NOTE: Registered Agent signature required when reinstating) DATE

**FILE NOW!!! FEE IS \$550.00
Due by September 8, 2004**

9. Election Campaign Financing
Trust Fund Contribution. ☐ \$5.00 May Be
Added to Fees

10. OFFICERS AND DIRECTORS

TITLE	PSD
NAME	FOSTER, SCOTT S
STREET ADDRESS	2030-A WASHINGTON STREET
CITY-ST-ZIP	HOLLYWOOD, FL 33020
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	
TITLE	
NAME	
STREET ADDRESS	
CITY-ST-ZIP	

**DO NOT WRITE
IN THIS SPACE**

12. I 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 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: [Signature]
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

7/1/04
Date

954-828-7337
Daytime Phone #

NMTI

NEURMYO - THERAPY, INC.

Attachment
44049137
#P92000011364

July 2, 2004

Re: Dr. Scott S. Foster, P.A.

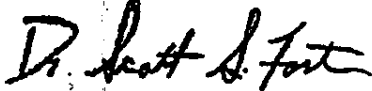
Dear State of Florida,

Enclosed please find my check for \$150.00 for the original fee. I apologize for sending this late, by my mother was terminally ill and subsequently passed away at the time these notices were due.

My history of 23 years of timely payments hopefully will show my intent.

Sincerely,

Dr. Scott S. Foster, P.A.



SSF/sp