

# 2001 UNIFORM BUSINESS REPORT (UBR)

DOCUMENT # P93000018955

1. Entity Name

ASSOCIATED CHIROPRACTIC PHYSICIANS, INC.

FILED

Apr 28, 2001 8:00 am  
Secretary of State

04-28-2001 90006 042 \*\*\*150.00

Principal Place of Business

2573 NORTH KINGS ROAD  
P.O. BOX 1678  
HILLIARD FL 32046  
US

Mailing Address

PO BOX 1678  
HILLIARD FL 32046

2. Principal Place of Business

3. Mailing Address

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Zip

Country

Zip

Country

4. FEI Number 59-3169023

Applied For

Not Applicable

5. Certificate of Status Desired

\$8.75 Additional  
Fee Required

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

KORNACKI, KERRY E  
2573 NORTH KINGS ROAD  
POST OFFICE BOX 1678  
HILLIARD FL 32046

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.

SIGNATURE

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

(NOTE: Registered Agent signature required when reinstating)

DATE

9. This corporation is eligible to satisfy its Intangible  
Tax filing requirement and elects to do so.  
(See criteria on back)

**FILE NOW!!! FEE IS \$150.00**  
**After MAY 1, 2001 Fee will be \$550.00**  
**Make Check Payable to Department of State**

10. Election Campaign Financing  
Trust Fund Contribution.

\$5.00 May Be  
Added to Fees

11. OFFICERS AND DIRECTORS

12. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11

TITLE P  
NAME KORNACKI, KERRY  
STREET ADDRESS RT 4 BOX 7379  
CITY-ST-ZIP HILLIARD FL 32046

TITLE  
NAME  
STREET ADDRESS  
CITY-ST-ZIP

TITLE M  
NAME KORNACKI, DEBRA  
STREET ADDRESS RT 4 BIX 7379  
CITY-ST-ZIP HILLIARD FL 32046

TITLE  
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CITY-ST-ZIP

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13. 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 recipient of the report as required by Chapter 607, Florida Statutes; and that my name appears in Block 11 or Block 12 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

CR2E034 (10/00)