
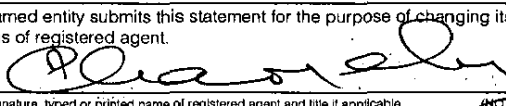
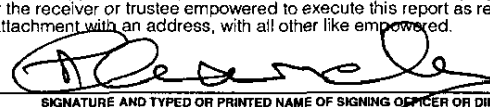


2004 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Mar 05, 2004 8:00 am
Secretary of State

03-05-2004 90021 009 ***150.00

DOCUMENT # P93000078427 1. Entity Name NEUROCARE ASSOCIATES, INC.					
Principal Place of Business 4900 W OAKLAND PARK BLVD SUITE 107 FT LAUDERDALE, FL 33313			Mailing Address 6574 N STATE RD 7 PMB 115 COCNUT CREEK, FL 33073-3617 US		
2. Principal Place of Business Suite, Apt. #, etc. Suite 105		3. Mailing Address Suite, Apt. #, etc. 			
City & State 		City & State 		4. FEI Number 65-0461509	
Zip 		Country 		5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required	
6. Name and Address of Current Registered Agent CHAMELY, ABRAHAM MD 4900 W OAKLAND PARK BLVD SUITE 107 FT LAUDERDALE, FL 33313				7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) Suite 105 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  DATE 3/1/04 <small>Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)</small>					
FILE NOW!!! FEE IS \$150.00 After May 1, 2004 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	SD CHAMELY, ABRAHAM MD % 4900 W OAKLAND PARK BLVD SUITE 107 FT LAUDERDALE, FL		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition Suite 105	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	PD LESSER, MARTIN A 2420 CASTILLA ISLE FT LAUDERDALE, FL		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
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: 			DATE: 3/1/04		
<small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR</small>			<small>Daytime Phone #</small>		