
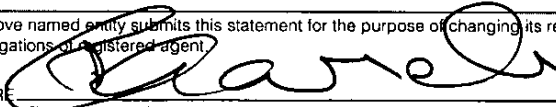
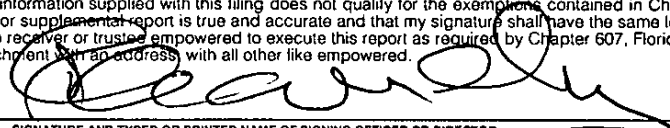


2006 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Feb 13, 2006 8:00 am
Secretary of State

02-13-2006 90007 016 ***150.00

DOCUMENT # P93000078427 1. Entity Name NEUROCARE ASSOCIATES, INC.					
Principal Place of Business 4900 W OAKLAND PARK BLVD SUITE 105 FT LAUDERDALE, FL 33313			Mailing Address 6574 NORTH STATE ROAD 7 PMB 106 COCONUT CREEK, FL 33073 US		
2. Principal Place of Business 6574 N.State Road 7		3. Mailing Address			
Suite, Apt. #, etc. PMB 106		Suite, Apt. #, etc.			
City & State Coconut Creek, Fl		City & State			
Zip 33073		Country USA		4. FEI Number 65-0461509	
5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required				Applied For <input type="checkbox"/> Not Applicable	
6. Name and Address of Current Registered Agent CHAMELY, ABRAHAM MD 4900 W OAKLAND PARK BLVD SUITE 105 FT LAUDERDALE, FL 33313			7. Name and Address of New Registered Agent Name Chamely, Abraham MD Street Address (P.O. Box Number is Not Acceptable) 6574 North State Road 7 PMB106 City Coconut Creek, FL 33073		
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  _____ <small>Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE</small>					
FILE NOW!!! FEE IS \$150.00 After May 1, 2006 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, STE. 105 FORT LAUDERDALE, FL 33313 <input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition 4070 NW 83rd Lane Coral Springs, Fl 33065	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	PD LESSER, MARTIN A 2420 CASTILLA ISLE FT LAUDERDALE, FL <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	
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 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:  _____ <small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #</small>					