

2006 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Feb 15, 2006 8:00 am
Secretary of State

02-15-2006 90025 032 ***150.00

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01302006 Chg-P CR2E034 (11/05)

DOCUMENT # P94000091775 1. Entity Name TREASURE COAST NEUROSURGICAL ASSOCIATES, P.A.					
Principal Place of Business 606 OAK HARBOUR DR JUNE BEACH, FL 33408			Mailing Address PO BOX 33718 PALM BEACH GARDENS, FL 33420-3718		
2. Principal Place of Business Suite, Apt. #, etc.			3. Mailing Address Suite, Apt. #, etc.		
City & State			City & State		
Zip		Country		4. FEI Number 65-0543439	
5. Certificate of Status Desired <input type="checkbox"/>		\$8.75 Additional Fee Required			
6. Name and Address of Current Registered Agent BLAND, LINDA 606 OAK HARBOUR DRIVE JUNO BEACH, FL 33408				7. Name and Address of New Registered Agent 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. I am familiar with, and accept the obligations of registered agent. SIGNATURE _____ DATE _____ <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, 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	D BLAND, DR. LINDA 606 OAK HARBOUR DRIVE JUNO BEACH, FL 33408 <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	
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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, and all other life empowered.					
SIGNATURE: _____ <small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR</small>			Date: 2/9/06 Daytime Phone # _____		