**FILE NOW: FILING FEE AFTER MAY 1 IS $225.00**

PROFIT CORPORATION ANNUAL REPORT **1996**

FLORIDA DEPARTMENT OF STATE
Sandra B. Mortham
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # P95000016746

1. Corporation Name

TRANSATLANTIC HEALTH RESOURCES CORPORATION

Principal Place of Business / Mailing Address

120 Lifestyle Blvd., #312
Palm Harbor FL 34685

3. Date Incorporated or Qualified: Sept. 16, 1995
3a. Date of Last Report:

2. Principal Place of Business
21 7325 Hideaway Trail
Suite, Apt. #, etc. 22
City & State 23 New Port Richey FL
Zip 24 34655 Country 25 Pasco

2a. Mailing Address
26
Suite, Apt. #, etc. 27
City & State 28
Zip 29 Country 30

4. FEI Number 59-3317394 [ ] Applied For [ ] Not Applicable

5. Certificate of Status Desired [ ] $8.75 Additional Fee Required

6. Election Campaign Financing Trust Fund Contribution [ ] $5.00 May Be Added to Fees

8. This corporation has liability for intangible tax under s. 199.032 Florida Statutes [ ] Yes [ ] No

9. Name and Address of Current Registered Agent

Zoltan Mayer, M.D.
120 Lifestyle Blvd., #312
Palm Harbor FL 34685

10. Name and Address of New Registered Agent

81 Name: Zoltan Mayer, M.D.
82 Street Address (P.O. Box Number is Not Acceptable): 7325 Hideaway Trail
83
84 City: New Port Richey FL 85 Zip Code: 34655

11. Pursuant to the provisions of Sections 607.0502 and 607.1508, Florida Statutes, the above named corporation submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with, and accept the obligations of, Section 607.0505, Florida Statutes.

SIGNATURE _____ DATE _____
Signature, Type or Print Name of Registered Agent and Title of Appointee (If Title Is Not Applicable, Signature Is Required Whenever Change)

12. OFFICERS AND DIRECTORS

| | | |
|---|---|---|
| TITLE | P/D | [ ] DELETE |
| NAME | Zoltan Mayer | |
| STREET ADDRESS | 7325 Hideaway Trail | |
| CITY-ST-ZIP | New Port Richey FL 34655 | |
| TITLE | C/V/D | [ ] DELETE |
| NAME | Doulgas Jordan, Jr. | |
| STREET ADDRESS | 8343 Berkley Drive | |
| CITY-ST-ZIP | Hudson FL 34667 | |
| TITLE | T/D | [ ] DELETE |
| NAME | Anette Mayer | |
| STREET ADDRESS | 7325 Hideaway Trail | |
| CITY-ST-ZIP | New Port Richey FL 34655 | |
| TITLE | S/D | [ ] DELETE |
| NAME | Mabel M. Wells | |
| STREET ADDRESS | 8543 Berkley Drive | |
| CITY-ST-ZIP | Hudson FL 34667 | |
| TITLE | | [ ] DELETE |
| NAME | | |
| STREET ADDRESS | | |
| CITY-ST-ZIP | | |
| TITLE | | [ ] DELETE |
| NAME | | |
| STREET ADDRESS | | |
| CITY-ST-ZIP | | |

13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12

| | | |
|---|---|---|
| 1.1 TITLE | | [ ] Change [ ] Addition |
| 1.2 NAME | | |
| 1.3 STREET ADDRESS | | |
| 1.4 CITY-ST-ZIP | | |
| 2.1 TITLE | | [ ] Change [ ] Addition |
| 2.2 NAME | | |
| 2.3 STREET ADDRESS | | |
| 2.4 CITY-ST-ZIP | | |
| 3.1 TITLE | | [ ] Change [ ] Addition |
| 3.2 NAME | | |
| 3.3 STREET ADDRESS | | |
| 3.4 CITY-ST-ZIP | | |
| 4.1 TITLE | | [ ] Change [ ] Addition |
| 4.2 NAME | | |
| 4.3 STREET ADDRESS | | |
| 4.4 CITY-ST-ZIP | | |
| 5.1 TITLE | | [ ] Change [ ] Addition |
| 5.2 NAME | | |
| 5.3 STREET ADDRESS | | |
| 5.4 CITY-ST-ZIP | | |
| 6.1 TITLE | | [ ] Change [ ] Addition |
| 6.2 NAME | | |
| 6.3 STREET ADDRESS | | |
| 6.4 CITY-ST-ZIP | | |

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14. I do hereby certify that the information supplied with this filing is voluntarily furnished and does not qualify for the exemption stated in Section 119.07(3)(k), Florida Statutes. I further certify that the information indicated on this annual report or supplemental annual 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 12 or Block 13 if changed, or on an attachment with an address.

**SIGNATURE:** X _____ Zoltan Mayer, M.D. 813/842-8468
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #