

# 2006 FOR PROFIT CORPORATION ANNUAL REPORT

**FILED**  
**Apr 24, 2006 08:00 AM**  
**Secretary of State**

**DOCUMENT # P95000018633**

1. Entity Name  
**CLINICAL TOUCH MASSAGE, INC.**



Principal Place of Business  
**4425 S PLEASANT HILL  
KISSIMMEE, FL 34746 US**

Mailing Address  
**PO BOX 156  
INTERCESSION CTY, FL 33848 US**



04182006 No Chg-P CR2E034 (11/05)

**DO NOT WRITE IN THIS SPACE**

|                                                           |                                                        |
|-----------------------------------------------------------|--------------------------------------------------------|
| 4. FEI Number<br><b>59-3310064</b>                        | Applied For<br><input type="checkbox"/> Not Applicable |
| 5. Certificate of Status Desired <input type="checkbox"/> | <b>\$8.75</b> Additional Fee Required                  |

**6. Name and Address of Current Registered Agent**

**BOYD, ADELE M  
1951 WINDWARD OAKS CT.  
KISSIMMEE, FL 34746**

**DO NOT WRITE  
IN THIS SPACE**

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

*Adele M Boyd*

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

(NOTE: Registered Agent signature required when reinstating)

**4/18/06**

DATE

**FILE NOW!!! FEE IS \$150.00  
After May 1, 2006 Fee will be \$550.00**

9. Election Campaign Financing  
Trust Fund Contribution. ☐

**\$5.00** May Be  
Added to Fees

**10. OFFICERS AND DIRECTORS**

|                |                             |
|----------------|-----------------------------|
| TITLE          | PSTD                        |
| NAME           | BOYD, ADELE M               |
| STREET ADDRESS | PO BOX 156                  |
| CITY-ST-ZIP    | INTERCESSION CITY, FL 33848 |

|                |                        |
|----------------|------------------------|
| TITLE          | MD                     |
| NAME           | BOYD, BRIAN            |
| STREET ADDRESS | PO BOX 156             |
| CITY-ST-ZIP    | INTERCESSION, FL 33848 |

|                |  |
|----------------|--|
| TITLE          |  |
| NAME           |  |
| STREET ADDRESS |  |
| CITY-ST-ZIP    |  |

|                |  |
|----------------|--|
| TITLE          |  |
| NAME           |  |
| STREET ADDRESS |  |
| CITY-ST-ZIP    |  |

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| TITLE          |  |
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| TITLE          |  |
| NAME           |  |
| STREET ADDRESS |  |
| CITY-ST-ZIP    |  |

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**DO NOT WRITE  
IN THIS SPACE**

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

*Adele M Boyd*

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

**4/18/06 (407)8475349**

Date

Daytime Phone #