


2006 FOR PROFIT CORPORATION ANNUAL REPORT (AR)

FILED
Mar 06, 2006 8:00 am
Secretary of State

03-06-2006 90031 018 ***150.00

DOCUMENT # PS6000026940 1. Entity Name ANESTHESIA PAIN CARE CONSULTANTS, INC.					
Principal Place of Business 7171 NORTH UNIVERSITY DRIVE SUITE 300 TAMARAC FL 33321			Mailing Address 7154 N UNIVERSITY DR 316 TAMARAC FL 33321 US		
2. Principal Place of Business Suite, Apt. #, etc.			3. Mailing Address Suite, Apt. #, etc.		
City & State			City & State		
Zip		Country		Zip	
Country		Country		4. FEI Number 65-0652448	
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 COEL, MARK A ESQ. ONE LINCOLN PLACE 1900 GLADES ROAD, SUITE 350 BOCA RATON FL 33431-0000				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 _____ (NOTE: Registered Agent signature required when reinstating) DATE _____					
FILE NOW!!! FEE IS \$150.00. After May 1, 2006 Fee Will Be \$550.00 Make Check Payable to Florida Department of State				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	PS FOX, IRA B 7777 N UNIVERSITY DRIVE SUITE 101 TAMARAC FL 33321	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	7154 N. UNIVERSITY DR #316 TAMARAC, FL 33321
TITLE NAME STREET ADDRESS CITY-ST-ZIP	VT LASNER, JAY E 7777 N UNIVERSITY DR SUITE 101 TAMARAC FL 33321	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	7154 N. UNIVERSITY DR. #316 TAMARAC, FL 33321
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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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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1st MOORE CR2E034 (10/05)

SIGNATURE:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

2/23/06

Date

954-720-3188

Daytime Phone #

12. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Section 119, Florida Statutes. I further certify that the information indicated on this report or supplemental reports 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.