


**2004 FOR PROFIT CORPORATION  
ANNUAL REPORT**

**FILED**  
**Jan 12, 2004 08:00 AM**  
**Secretary of State**

<b>DOCUMENT # P96000039702</b> 1. Entity Name <b>PHYSICIANS INJURY CARE CENTER, INC.</b>	
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Principal Place of Business  
**5287 ALHAMBRA DRIVE  
ORLANDO, FL 32808**

Mailing Address  
**5287 ALHAMBRA DRIVE  
ORLANDO, FL 32808**



01072004 No Chg-P CR2E034 (10/03)

**DO NOT WRITE IN THIS SPACE**

4. FEI Number <b>59-3377120</b>	Applied For <input type="checkbox"/> Not Applicable
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5. Certificate of Status Desired <input type="checkbox"/>	<b>\$8.75</b> Additional Fee Required
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**6. Name and Address of Current Registered Agent**

**COLVIN, ROBERT  
5287 ALHAMBRA DRIVE  
ORLANDO, FL 32808**

**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 \_\_\_\_\_

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

(NOTE: Registered Agent signature required when reinstating)

DATE \_\_\_\_\_

**FILE NOW!!! FEE IS \$150.00  
After May 1, 2004 Fee will be \$550.00**

9. Election Campaign Financing  
Trust Fund Contribution. ☐

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

**10. OFFICERS AND DIRECTORS**

TITLE NAME STREET ADDRESS CITY-ST-ZIP	PTSD COLVIN, ROBERT 5287 ALHAMBRA DRIVE ORLANDO, FL 32808
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01/13/04-80062-016 150.00

**DO NOT WRITE  
IN THIS SPACE**

12. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(i), 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 lines empowered.

SIGNATURE: \_\_\_\_\_

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

1/8/04

Date

407-295-1441

Daytime Phone #