


**2008 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED
Feb 04, 2008 08:00 AM
Secretary of State

DOCUMENT # P98000061683 1. Entity Name CEDERQUIST MEDICAL WELLNESS CENTER, INC.	
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Principal Place of Business 1575 PINE RIDGE ROAD SUITE 19 NAPLES, FL 34109	Mailing Address 1575 PINE RIDGE ROAD SUITE 19 NAPLES, FL 34109
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DO NOT WRITE IN THIS SPACE

01182008 No Chg-P CR2E034 (11/05)


4. FEI Number 59-3529688	Applied For Not Applicable
5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required	

6. Name and Address of Current Registered Agent

**CEDERQUIST, CAROLINE J M.D.
7206 MILL RUN CIRCLE
NAPLES, FL 34109**

**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  DATE _____
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)

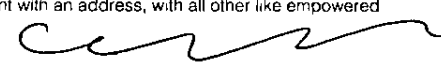
FILE NOW!!! FEE IS \$150.00 After May 1, 2008 Fee will be \$550.00	9. Election Campaign Financing Trust Fund Contribution. <input type="checkbox"/> \$5.00 May Be Added to Fees	U000000813873 02/13/08-80022-006 150.00
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10. OFFICERS AND DIRECTORS

TITLE NAME STREET ADDRESS CITY-ST-ZIP	P CEDERQUIST, CAROLINE J M.D. 7206 MILL RUN CIR NAPLES, FL 34109
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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:  **SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR** _____
Date _____ Daytime Phone # _____