


2006 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Sep 12, 2006 8:00 am
Secretary of State

04-03-2006 90371 030 *****8.75
09-12-2006 90008 023 ***550.00

| | | | | | |
|---|--|---|--|---|--|
| DOCUMENT # P99000024115 | | | |  | |
| 1. Entity Name CHIROPRACTIC PHYSICIANS REHABILITATION NETWORK INC. | | | | | |
| Principal Place of Business 2711 MICHIGAN AVE KISSIMMEE, FL 34744 | | | Mailing Address CPRN P.O. BOX 452272 KISSIMMEE, FL 34744 | | |
| 2. Principal Place of Business | | | 3. Mailing Address | | |
| Suite, Apt. #, etc. | | | Suite, Apt. #, etc. | | |
| City & State | | | City & State | | |
| Zip | | Country | | Zip | |
| Country | | Country | | 08222006 Chg-P CR2E034 (11/05) | |
| 4. FEI Number 59-3559465 | | | | 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 | | | 7. Name and Address of New Registered Agent | | |
| RODRIGUEZ, PHRANKIE 12900 LOS ALAMITOS CT ORLANDO, FL 32837 | | | 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 _____ <small>Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE</small> | | | | | |
| FILE NOW!!! FEE IS \$550.00 Due by September 6, 2006 | | 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 | D RODRIGUEZ, PHRANKIE 12900 LOS ALAMITOS CT ORLANDO, FL 32837 | <input type="checkbox"/> Delete | | | |
| TITLE NAME STREET ADDRESS CITY - ST - ZIP | | <input type="checkbox"/> Delete | | | |
| TITLE NAME STREET ADDRESS CITY - ST - ZIP | | <input type="checkbox"/> Delete | | | |
| TITLE NAME STREET ADDRESS CITY - ST - ZIP | | <input type="checkbox"/> Delete | | | |
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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"/> Delete | | | |
| 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. | | | 9-04-06 407 931-3200 | | |
| SIGNATURE: _____ <small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR</small> | | | Date Daytime Phone # | | |

ATTACHMENT
C.P.R.N. Chiropractic **Physicians**
Rehab-Network

September 4, 2006

40103921

#P9900002415

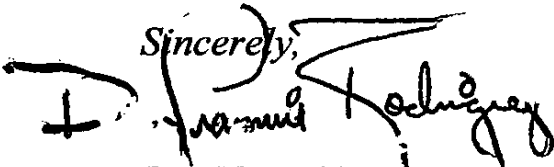
From: Dr. Phrankie Rodriguez
C.P.R.N.
2711 Michigan Ave.
Kissimmee, FL 34744

To: Division of Cooperation
P.O. Box 1500
Tallahassee, FL 32302-1500

To Whom It May Concern:

The purpose of this letter is to explain the fact, that I did not receive my annual report renewal letter. Enclosed you'll find 2006 annual report document. If we can be of any further assistance please do not hesitate in contacting me.

Sincerely,


Dr. Phrankie Rodriguez