


2006 FOR PROFIT CORPORATION ANNUAL REPORT

FILED
Sep 07, 2006 08:00 AM
Secretary of State

DOCUMENT # P99000039909
 1. Entity Name
CLARENCE COHEN, P.A.



Principal Place of Business
ATLANTIC THERAPETICS
1925 E ATLANTIC BLVD
POMPANO BEACH, FL 33060

Mailing Address
2291 NW 129TH TERR
PEMBROKE PINES, FL 33028

Clarence L Cohen MD



DO NOT WRITE IN THIS SPACE

08022006 No Chg-P CR2E034 (11/05)

4. FEI Number 65-0924519	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
COHEN, CLARENCE
2291 NW 129TH TERR
PEMBROKE PINES, FL 33028

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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
Due by September 6, 2006

9. Election Campaign Financing Trust Fund Contribution. **\$5.00** May Be Added to Fees

In accordance with s. 607.193(2)(b), F.S., the corporation did not receive the prior notice.

10. OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	P COHEN, CLARENCE 2291 NW 129TH TERR PEMBROKE PINES, FL 33028
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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: *Clarence L Cohen MD* **8/31/06** **954-499-0443**
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #