

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION
FOR
REINSTATEMENT



FLORIDA DEPARTMENT OF STATE

Jim Smith

Secretary of State

DIVISION OF CORPORATIONS

FILED

02 NOV -1 PM 2:22

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P00000048242

1. Corporation Name

TRIPLE O MEDICAL SERVICES, INC.

Principal Place of Business

1411 N FLAGLER DRIVE
9000
WEST PALM BEACH FL 33401

Mailing Address

1411 N FLAGLER DRIVE
9000
WEST PALM BEACH FL 33401

If above addresses are incorrect in any way, line through incorrect information and enter correction below.

2. New Principal Office Address, If Applicable

Suite, Apt. #, etc.

City & State

Zip

Country

3. New Mailing Office Address, If Applicable

Suite, Apt. #, etc.

City & State

Zip

Country

4. Date Incorporated or Qualified
To Do Business in Florida

05/15/2000

5. FEI Number

65-1015825

- Applied For

Not Applicable

6. CERTIFICATE OF STATUS DESIRED ☐

\$8.75 Additional Fee required
for a Certificate of Status

7. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at least 3 directors)

Title(s) 1	Name of Officers and/or Directors 2	Street Address of Each Officer and/or Director 3	City / State / Zip 4
P	OSIYEMI, OLAYEMI	1411 N FLAGLER DRIVE STE 9000	WEST PALM BEACH FL 33401

8. Name and Address of Current Registered Agent

OSIYEMI, OLAYEMI
1733 VILLAGE BLVD., APT., 112
WEST PALM BEACH FL 33409

9. Name and Address of New Registered Agent

Name

Street Address (P.O. Box Number is Not Acceptable)

1411 North Flagler Street

Suite/Apt. #, Etc.

9000

City

West Palm Beach

State

FL

Zip Code

33401

10. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of Section 607.0505, F.S. or 617.0505, F.S.

Signature of
Registered Agent

SIGNATURE REQUIRED

REGISTERED AGENT MUST SIGN

Date

10/28/2

11. I certify that I am an officer or director or the receiver or trustee empowered to execute this application as provided for in chapter 607 or 617, F.S. I further certify that when filing this reinstatement application, the reason for dissolution has been eliminated, the corporate name satisfies the requirements of section 607.0401 or 617.0401, F.S., that all fees owed by the corporation have been paid and the names of individuals listed on this form do not qualify for an exemption under section 119.07(3)(i), F.S. The information indicated on this application is true and accurate, and my signature shall have the same legal effect as if made under oath.

SIGNATURE:

SIGNATURE REQUIRED

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

OSIYEMI OLAYEMI M-D 10/28/2 (561)832-6770

CR2E040 (8/02)