PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Glenda E. Hood
Secretary of State
DIVISION OF CORPORATIONS

FILED
03 OCT 21 AM 10:47
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # **P95000074643**

1. Corporation Name

ARTHRITIS & RHEUMATISM ASSOCIATES, P.A.

Principal Place of Business	Mailing Address
520 D STREET SUITE C CLEARWATER FL 34616	520 D STREET SUITE C CLEARWATER FL 34616

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

REINSTATEMENT 03

2. New Principal Office Address, If Applicable	3. New Mailing Office Address, If Applicable
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State	City & State
Zip / Country	Zip / Country

4. Date Incorporated or Qualified To Do Business in Florida: 09/27/1995

5. FEI Number: 59-3337044 ☐ 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)

1 Title(s)	2 Name of Officers and/or Directors	3 Street Address of Each Officer and/or Director	4 City / State / Zip
D	ROSEN, ADAM M MD	520 D STREET SUITE C	CLEARWATER FL ~~34616~~ 33756

300023968903
10/21/03--01058--012 **150.00

8. Name and Address of Current Registered Agent	9. Name and Address of New Registered Agent
GASSMAN, ALAN S ESQ. 1245 COURT STREET, SUITE 102 CLEARWATER FL 34616	Name Street Address (P.O. Box Number is Not Acceptable) Suite, Apt. #, Etc. City / State FL / Zip Code

CR2E040 (7/03)

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 Date: _____
REGISTERED AGENT MUST SIGN

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 ADAM M ROSEN, MD 10/10/03 727-443-6400
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

ARTHRITIS & RHEUMATISM ASSOCIATES PA

ADAM M ROSEN MD · TATIANA NAGIBINA MD · EILEEN PERRY ARNP

SPECIALIZING IN THE TREATMENT OF ARTHRITIS, OSTEOPOROSIS AND AUTOIMMUNE DISEASES

October 10, 2003

Department of State
Division of Corporations
PO Box 6327
Tallahassee, FL 32314

To The Secretary of State:

This letter is being sent in response to the notice of revocation we received yesterday, October 9, 2003. This is the first notice we have received regarding our 2003 UBR.

We checked our records and find we did not receive notification of payment. It appears the zip code is wrong on the application for reinstatement that could possibly explain why we did not receive notice. The correction has been made on the form.

We ask that you waive the reinstatement fee at this time. A check for $150.00 is enclosed.

Thank you for your consideration in this matter.

Sincerely,

Adam M. Rosen, MD, FACR, FACP

AMR/sas

520 D STREET SUITE C CLEARWATER FL 33756
PHONE 727 443 6400 FAX 727 443-5590