

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

10F2

CORPORATION  
REINSTATEMENT



FLORIDA DEPARTMENT OF STATE  
Secretary of State  
DEPARTMENT OF CORPORATIONS

FILED

01 JAN 19 AM 9:58

SECRETARY OF STATE  
TALLAHASSEE FLORIDA

DOCUMENT # PO8000052802

1. Corporation Name

Anesthesia Outpatient Solutions, P.A.

2. Principal Office Address

Drive

3. Mailing Office Address

Same

8858 Steeplechase

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Palm Beach Gardens FL

"

Zip

Country

Zip

Country

33418

U.S.

"

"

4. Date Incorporated or Qualified To Do Business in Florida

6-11-98

5. FEI Number

65-0859439

Applied For

Not Applicable

6. CERTIFICATE OF STATUS DESIRED

\$8.75 Additional Fee required for a Certificate of Status

7. Name and Address of Current Registered Agent

Name

Ramon Alvarez

200003632022-2

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

8858 Steeplechase Drive

-02/05/01--01008--01

\*\*\*450.00 \*\*\*450.00

Suite, Apt. #, Etc.

City

Palm Beach Gardens

State

FL

Zip Code

33418

8. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of section 607.0505 or 617.0503, F.S.

Signature of Registered Agent

[Signature]  
REGISTERED AGENT MUST SIGN

Date

1/10/01

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

Titles	Name of Officers and/or Directors	Street Address of Each Officer and/or Director	City / State / Zip
<u>Pres.</u>	<u>Ramon Alvarez</u>	<u>Same as Box # 2</u>	
<u>VP</u>	<u>Patricia Alvarez</u>	<u>"</u>	

10. 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]  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

1/10/01 (561) 627-5411

Date

Daytime Phone #

KE

CR2E081 (9/00)

2082  
4-1-01

Re: Anesthesia Outpatient Solutions, P.A.

To Whom it may concern,

I am writing you regarding  
the above-referenced corporation  
which was administratively  
dissolved on 9/24/99.

We moved on 12/5/98 to a  
new home and apparently the  
mailings from you were never  
forwarded to our new address.  
This is a new corporation and  
we were not even aware that  
we had to file an annual  
report. Please reinstate  
this corporation.

Thank you.

Patricia Alvarez

