PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

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APPLICATION FOR ~~REINSTATEMENT~~

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

P00000012796

FILED
00 DEC 20 AM 10:53
SECRETARY OF STATE
TALLAHASSEE FLORIDA

DOCUMENT # P99000012796

1. Corporation Name

APOLLO MEDICAL CENTER, P.A.

Principal Place of Business	Mailing Address
7134 S.R. 54 NEW PORT RICHEY FL 34653	7134 S.R. 54 NEW PORT RICHEY FL 34653

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

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: 02/09/1999

5. FEI Number: 59-3554382 ☐ 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
D	CHOWDAPPA, JAY M.D.	7134 S.R. 54	NEW PORT RICHEY FL 34653
			200003514642--0
			-12727/00--01072--007
			****150.00 ****150.00

8. Name and Address of Current Registered Agent

FLORIDA INCORPORATORS, INC.
1221 BRICKELL AVENUE
SUITE 900
MIAMI FL 33131

9. Name and Address of New Registered Agent

Name: CHOWDAPPA, JAY
Street Address (P.O. Box Number is Not Acceptable): 7134 SR 54
Suite, Apt. #, Etc.:
City: NEW PORT RICHEY State: FL Zip Code: 34653

CR2E040 (8/00)

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.

Signature of Registered Agent: SIGNATURE REQUIRED Date: 12/1/00
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.

KE

SIGNATURE: SIGNATURE REQUIRED 12/1/00 727-375-0848
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

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APOLLO MEDICAL CENTER. P.A.

Jay Chowdappa, M.D.

7134 SR. 54
NEW PORT RICHEY, FL. 34653
(727) 375-0848

12134 Cobblestone Dr.
HUDSON, FL. 34667
(727) 862-238

12/15/00

To

Division of Corporations
Annual report/Reinstatement section
Box 6327
Tallahassee, Fl 32314-6327

RE: Reinstatement of Apollo Medical Center P.A.

Dear officer,

I received a notification asking to reinstate the corporation in Nov '2000. The earlier reminders from you must have gone to the registerd agent Florida Incorporators, Inc Which I am not able to contact and I suspect that it does not exist anymore.

Because of this, I am sending in the reinstatement application late along with the fee of $ 150.00 towards annual report and Corporate supplemental fee. I also request you to waive the reinstatement fee of $ 600.00.

Sincerely

Jay Chowdappa.