PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT 02 UBa

FLORIDA DEPARTMENT OF STATE
Jim Smith
Secretary of State
DIVISION OF CORPORATIONS

FILED
02 OCT 30 AM 9:32
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

400008693924
10/30/02--01032--015 **150.00

8. Name and Address of Current Registered Agent	9. Name and Address of New Registered Agent
CHOWDAPPA, JAY 7134 S.R. 54 NEW PORT RICHEY FL 34653	Name Street Address (P.O. Box Number is Not Acceptable) Suite, Apt. #, Etc. City / State: FL / Zip Code

CR2E040 (8/02)

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: 10/25/2

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 JAY CHOWDAPPA, MD — Date: 10/25/2 — Daytime Phone #: 7273750198

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

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) 862-2388

Florida Department of State
Jim Smith
Secretary Of State
Division of Corporations
P.O. Box 6327
Tallahassee, FL 32314

Dear Sir or Madam,

This letter is to request that the penalty fee for late renewal/reinstatement be waived due to the fact that the two prior UBR notices were not received. Please accept the enclosed check and application for reinstatement without penalty.

Sincerely,

10/25/2

Jayadeva Chowdappa, M.D.
Apollo Medical Center

JC/mhm