

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION
FOR
REINSTATEMENT



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

DOCUMENT # P99000084702

1. Corporation Name

DOCTOR'S RESOURCE GROUP, INC.

Principal Place of Business

490 JAMES RIVER RD.
GULF BREEZE FL 32561

Mailing Address

PO BOX 847
GULF BREEZE FL 32562-0847

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

09/20/1999

5. FEI Number

63-1234842

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	MEADE, JOHN L M.D.	490 JAMES RIVER RD.	GULF BREEZE FL 32561
D	WRIGHT, GARY D M.D.	490 JAMES RIVER RD.	GULF BREEZE FL 32561

700023853527
10/16/03--01038--015 **150.00

8. Name and Address of Current Registered Agent

FERGUSON, MICHAEL L
4300 BAYOU BLVD., STE. 13
PENSACOLA FL 32503

9. Name and Address of New Registered Agent

Name

John L. Meade, MD

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

490 James River Rd

Suite, Apt. #, Etc.

City

Gulf Breeze

State

FL

Zip Code

32561

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]

REGISTERED AGENT MUST SIGN

Date 10-13-03

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]

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

John L. Meade, MD

10-13-03

Date

850-916-0272

Daytime Phone #

CR2040 (7/03)



Doctor's Resource Group, Inc.

Monday, October 13, 2003

Division of Corporations
Annual Report/Reinstatement Section
PO Box 6327
Tallahassee, FL 32314-6327

Re: Waiver of Reinstatement Fee

Dear Sir or Madam:

I am requesting waiver of the reinstatement fee for Doctor's Resource Group, Inc. (as well as our sister company, Emerald Healthcare Group, PA.). Our shared manager was recently found to have been embezzling monies, as well as simply failing to fulfill her required duties. After her termination, I took over gathering the mail, and have now received your notice of dissolution of our corporation.

I am enclosing a money order for \$150.00, and ask your indulgence in this matter.

Thank you,

A handwritten signature in black ink, appearing to read 'John L. Meade'.

John L. Meade, MD, FACEP
Chief Executive Officer