PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT



FLORIDA DEPARTMENT OF STATE Katherine Harris

Secretary of State

DIVISION OF CORPORATIONS

DOCUMENT #

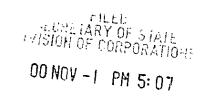
628023

1. Corporation Name

CARLOS J. GONZALEZ, M.D., P.A.

Principal Place of Business

Mailing Address



2321 US HWY 27 NORTH P.O. BOX AVON PARK FL 33825 AVON PA US				70 FL 33825		REINSTATEMENT OO			
If above addresses are incorrect in any way, line through incorrect information and enter corre						7.200			
New Principal Office Address, if Applicable 3. New Mailin				ng Office Address, If Applicable		4. Date Incorporated or Qualified To Do Business in Florida 07/01/1979			
Suite, Apt. #, etc. Suite, Apt.				‡, etc.		5 FFI Numbe	5. FEI Number Applied For		
City & State			City & State	City & State			EQ-1014197		Not Applicable
Zip Country		Country	Zip	Cour	Country		6. \$8.75 Additional Fee required		
ZIP						CERTIFICATI	E OF STATUS DESIRED	for a Ce	rtificate of Status
7. Names a	and Street Addre	sses of Each Officer and	l/or Director (Flo		orations must list at le				
Title(s)	_	Name of Officers and/or Directors				City / State / Zi		p	
1	2		3				4		
P	GONZALEZ,	CARLOS J.		2321 US HW	Y 27 NORTH		AVON PARK FL		
	8. Name a	and Address of Curren	t Registered Age	nt	Name	of al	00034 -11/17, ****?	50.88 **	\$52 0017 **750.00
GONZALEZ, CARLOS J., M.D.					Street Address	Street Address (P.O. Box Number is Not Acceptable)			
2321 US HWY 27 N					Suite, Apt. #, Etc.				
AVON PARK FL 33825					Suite, Apr. #, E	ic.			
					City			State Zip	Code
Signature of Registered 11. I certify this reir owed b	Agent	egistered agent of the at	PEGISTERED AG	ENT MUST SIGN npowered to execute eliminated, the contract to	te this application as	s provided for in chass the requirements	Date	5. I further certify	S., that all fees (
SIGNA	TURE:	ATURE AND TYPED OR PI		hm			Date	Daytime F	Phone:#