F05000000621

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP ☐ WAIT ☐ MAIL

(Business Entity Name)

(Document Number)

Certified Copies _____ Certificates of Status _____

Special Instructions to Filing Officer:

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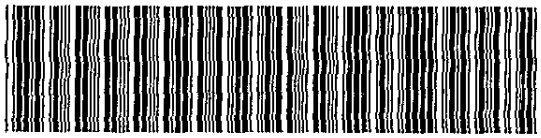

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TALLAHASSEE, FLORIDA

02/03/05

TRANSMITTAL LETTER

TO: *Registration Section*
Division of Corporations

SUBJECT: STOVER INSTITUTE FOR MEDICAL PROFESSIONALS, INC.
(Name of corporation - must include suffix)

Dear Sir or Madam:

The enclosed "Application by Foreign Corporation for Authorization to Transact Business in Florida," "Certificate of Existence," and check are submitted to register the above referenced foreign corporation to transact business in Florida.

Please return all correspondence concerning this matter to the following:

CARRIE NORTHCUTT
(Name of Person)

STOVER INSTITUTE FOR MEDICAL PROFESSIONALS, INC.
(Firm/Company)

90 CLARKSON WILSON CENTER PMB #482
(Address)

CHESTERFIELD, MO 63017
(City/State and Zip code)

For further information concerning this matter, please call:

CARRIE NORTHCUTT at (314) 374-1197
(Name of Person) (Area Code & Daytime Telephone Number)

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TALLAHASSEE, FLORIDA

STREET ADDRESS:
Registration Section
Division of Corporations
409 E. Gaines St.
Tallahassee, FL 32399

MAILING ADDRESS:
Registration Section
Division of Corporations
P.O. Box 6327
Tallahassee, FL 32314

Enclosed is a check for the following amount:

☐ $70.00 Filing Fee ☒ $78.75 Filing Fee & Certificate of Status ☐ $78.75 Filing Fee & Certified Copy ☐ $87.50 Filing Fee, Certificate of Status & Certified Copy

APPLICATION BY FOREIGN CORPORATION FOR AUTHORIZATION TO TRANSACT BUSINESS IN FLORIDA

IN COMPLIANCE WITH SECTION 607.1503, FLORIDA STATUTES, THE FOLLOWING IS SUBMITTED TO REGISTER A FOREIGN CORPORATION TO TRANSACT BUSINESS IN THE STATE OF FLORIDA.

1. STOVER INSTITUTE FOR MEDICAL PROFESSIONALS, INC.
(Enter name of corporation; must include "INCORPORATED," "COMPANY," "CORPORATION," "Inc.," "Co.," "Corp," "Inc," "Co," or "Corp.")

(If name unavailable in Florida, enter alternate corporate name adopted for the purpose of transacting business in Florida)

2. MISSOURI (State or country under the law of which it is incorporated)

3. _____ (FEI number, if applicable)

4. 1-12-05 (Date of incorporation)

5. perpetual (Duration! Year corp. will cease to exist or "perpetual")

6. _____ (Date first transacted business in Florida, if prior to registration)
(SEE SECTIONS 607.1501 & 607.1502, F.S., to determine penalty liability)

7. 50 CLARKSON WILSON CENTER PMB# 482 (Principal office address) CHESTERFIELD, MO 63017

50 CLARKSON WILSON CENTER, PMB# 482 (Current mailing address) CHESTERFIELD, MO 63017

8. Phlebotomy training (Purpose(s) of corporation authorized in home state or country to be carried out in state of Florida)

9. Name and street address of Florida registered agent: (P.O. Box NOT acceptable)

Name: TRICIA LYONS

Office Address: 10521 N. KENDALL DR. STE E-105

MIAMI (City), Florida 33176 (Zip code)

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TALLAHASSEE, FLORIDA

10. **Registered agent's acceptance:**
Having been named as registered agent and to accept service of process for the above stated corporation at the place designated in this application, I hereby accept the appointment as registered agent and agree to act in this capacity. I further agree to comply with the provisions of all statutes relative to the proper and complete performance of my duties, and I am familiar with and accept the obligations of my position as registered agent.

Tricia Lyons
(Registered agent's signature)

11. Attached is a certificate of existence duly authenticated, not more than 90 days prior to delivery of this application to the Department of State, by the Secretary of State or other official having custody of corporate records in the jurisdiction under the law of which it is incorporated.

12. Names and business addresses of officers and/or directors:

A. DIRECTORS

Chairman: MATT STOVER

Address: 50 CLARKSON WILSON CENTER PMB #482
CHESTERFIELD, MO 63017

Vice Chairman: _____

Address: _____

Director: _____

Address: _____

Director: _____

Address: _____

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B. OFFICERS

President: MATT STOVER

Address: 50 CLARKSON WILSON CENTER PMB #482
CHESTERFIELD, MO 63017

Vice President: _____

Address: _____

Secretary: MATT STOVER

Address: 50 CLARKSON WILSON CENTER PMB #482

Treasurer: MATT STOVER

Address: 50 CLARKSON WILSON CENTER PMB #482

NOTE: If necessary, you may attach an addendum to the application listing additional officers and/or directors.

13. _____
(Signature of Director or Officer listed in number 12 of the application)

14. MATT STOVER
(Typed or printed name and capacity of person signing application)

STATE OF MISSOURI

Robin Carnahan
Secretary of State

CORPORATION DIVISION

CERTIFICATE OF GOOD STANDING

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

I, ROBIN CARNAHAN, Secretary of the State of Missouri, do hereby certify that the records in my office and in my care and custody reveal that

STOVER INSTITUTE FOR MEDICAL PROFESSIONALS, INC.
00632693

was created under the laws of this State on the 12th day of January, 2005, and is in good standing, having fully complied with all requirements of this office.

IN TESTIMONY WHEREOF, I have set my hand and imprinted the GREAT SEAL of the State of Missouri, on this, the 20th day of January, 2005

Robin Carnahan
Secretary of State

Certification Number: 7311326-1 Reference:
Verify this certificate online at http://www.sos.mo.gov/businessentity/verification