PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT

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

03

FILED
03 FEB 18 AM 9:48
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

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02/18/03--01040--004 **150.00

DOCUMENT # F80791

1. Corporation Name

ARCADIA INTERNAL MEDICINE ASSOCIATES, P.A.

Principal Place of Business	Mailing Address
830 N MILLS AVE ARCADIA FL 33821	830 N MILLS AVE ARCADIA FL 33821

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: 05/11/1982

5. FEI Number: 52-1758572 ☐ 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
P	NATHAN, VAIDY	830 N MILLS RD	ARCADIA, FL 00000

8. Name and Address of Current Registered Agent

BROWN, FLETCHER
124 NORTH BREVARD, P.O. BOX 349
ARCADIA FL 33821

9. Name and Address of New Registered Agent

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:

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 2/12/03

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

VAIDY NATHAN, M.D., F.A.C.P.
INTERNAL MEDICINE AND GERIATRICS
CLINICAL ASSISTANT PROFESSOR OF MEDICINE
UNIVERSITY OF SOUTH FLORIDA
830 NORTH MILLS AVENUE
ARCADIA, FLORIDA 34266
TELEPHONE (941) 494-6599
FAX (941) 494-5467

February 12, 2003

Department of State
Division of Corporations
P.O. Box 6327
Tallahassee, FL 32314

Dear Sir,

Enclosed you will find a check in the amount of $150.00. In error we did not submit the check with the application form. We have enclosed a copy of the application form.

Thanking you in advance for you time and consideration in this matter. If you have any questions please call the above mumber.

Sincerely,

Vaidy Nathan, M.D.

Enclosures

VN/kc