PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Katherine Harris
Secretary of State
DIVISION OF CORPORATIONS

FILED
00 OCT 25 PM 4:49
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # **F81078**

1. Corporation Name

WEST FLORIDA MEDICAL CENTER CLINIC, P.A.

Principal Place of Business	Mailing Address
8333 NORTH DAVIS HIGHWAY PENSACOLA FL 32514	8333 NORTH DAVIS HIGHWAY PENSACOLA FL 32514

REINSTATEMENT 2000

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: 05/13/1982

5. FEI Number: 59-2193856 — 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
V	BROWN, J.M. M	8333 N. DAVIS HWY	PENSACOLA FL
P	~~B.D. MILLER, MD~~ M. R. Redmond, M.D.	8333 N DAVIS HWY	PENSACOLA FL
S D	~~KATTNER, M.M.~~ J. J. Varenholt, M.D.	8333 N DAVIS HWY	PENSACOLA FL
			300003493083--1 -12/11/00--01027--011 ****750.00 ****750.00

8. Name and Address of Current Registered Agent

~~AMOS, E. H.~~ Redmond, M. R.
8333 NO. DAVIS HWY.
PENSACOLA FL 32514

9. Name and Address of New Registered Agent

Name: M. R. REDMOND, M.D.
Street Address (P.O. Box Number is Not Acceptable): 8333 NORTH DAVIS HIGHWAY
Suite, Apt. #, Etc.:
City: PENSACOLA | State: FL | Zip Code: 32514

CR2E040 (8/00)

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.

Signature of Registered Agent: M. R. REDMOND, M.D. Date: 10/12/00
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: J. J. VARENHOLT, M.D. 10/11/00 8504248773
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #