

FLORIDA DEPARTMENT OF STATE Secretary of State

DIVISION OF CORPORATIONS

DOCUMENT #	F98000003118
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1. Corporation Name

REINSTATEMENT

KELSON PHYSICIAN PARTNERS OF JACKSONVILLE, INC.

2. Principal Office Addre	988	3. Mailing Office Addres	ss
90 State Hous	se Square	90 State House	e Square
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
10th Floor		10th Floor	
City & State		City & State	
Hartford, CT		Hartford, CT	
Zip	Country	Zip	Country
06103	USA	06103	USA

REINSTATE	MENT
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4. Date Incorporated or Quali	fied			
To Do Business in Florida	June	2,	1998	
5. FEI Number				Applied For
06-1513783				Not Applicable

CERTIFICATE OF STATUS DESIRED	S8.75 Additional Fee requir
	Tot a certificate of States

Name	•••	
Corporation Service Company		
Street Address (P.O. Box Number is Not Acceptable)		
1201 Hays Street		
Suite, Apt. #, Etc.	-	
City	State	Zip Code
Tallahassee	FL	32301-2525

I, being appointed the registered agent of the above named corporat	on, am familiar with and accept the obligations of section 607.0505 or 617.0503, F.S.

Deborah D.

10/6/03

9. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at least 3 directors)

Titles	Name of Officers and/or Directors E. Harry Creasey	Street Address of Each Officer and/or Director	City / State / Zip	
P/D		90 State House Square, 10th Fl.	Hartford, CT 06103	
S/D	Jeffrey Kinell	90 State House Square, 10th Fl.	Hartford, CT 06103	
		00	0023587520	

10. 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 filling 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:

(Jeffrey Kinell)

(860) 548-9940

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #



ACCOUNT NO. : 072100000032

REFERENCE

5212-722586

AUTHORIZATION

COST LIMIT : \$ 900.00

ORDER DATE: October 2, 2003

ORDER TIME: 4:09 PM

ORDER NO. : 265212-030

CUSTOMER NO: 7225868

CUSTOMER: Ms. Kathleen A. Ellison

Mintz, Levin, Cohn, Ferris,

20th Floor, 20th 157 Church Street New Haven, CT 06510

DOMESTIC FILINGS

NAME:

KELSON PHYSICIAN PARTNERS OF

JACKSONVILLE, INC.

XX REINSTATEMENT

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

CERTIFIED COPY
XX PLAIN STAMPED COPY

CERTIFICATE OF GOOD STANDING

CONTACT PERSON: Troy Todd

EXAMINER'S INITIALS

RECEIVED

03 OCT -6 PN 12: 55

CORPORATION