

# 2011 FOR PROFIT CORPORATION REINSTATEMENT

DOCUMENT# G46049

FILED  
Dec 05, 2011  
Secretary of State

**Entity Name:** HARLAN S. CHIRON, M.D., P.A.

**Current Principal Place of Business:**

SOUTH FLORIDA ORTHOPEDIC ASSOC  
4675 PONCE DE LEON BLVD, STE 203  
CORAL GABLES, FL 33146 US

**New Principal Place of Business:**

**Current Mailing Address:**

SOUTH FLORIDA ORTHOPEDIC ASSOC  
4675 PONCE DE LEON BLVD, STE 203  
CORAL GABLES, FL 33146 US

**New Mailing Address:**

FEI Number: 59-2305406      FEI Number Applied For ( )      FEI Number Not Applicable ( )      Certificate of Status Desired ( )

**Name and Address of Current Registered Agent:**

CHIRON, HARLAN S. MD  
4675 PONCE DE LEON BLVD  
STE 203  
CORAL GABLES, FL 33146 US

**Name and Address of New Registered Agent:**

The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida.

SIGNATURE: HARLAN S. CHIRON MD

\_\_\_\_\_  
Electronic Signature of Registered Agent

\_\_\_\_\_  
Date

**OFFICERS AND DIRECTORS:**

Title: PDT  
Name: CHIRON, HARLAN S MD  
Address: 4675 PONCE DE LEON BLVD., STE. 203  
City-St-Zip: CORAL GABLES, FL 33146

I hereby certify that the information indicated on this report or supplemental report is true and accurate and that my electronic signature shall have the same legal effect as if made under oath; that I am an officer or director of the corporation or the receiver or trustee empowered to execute this report as required by Chapter 607, Florida Statutes; and that my name appears above, or on an attachment with all other like empowered.

SIGNATURE: HARLAN S CHIRON MD

\_\_\_\_\_  
Electronic Signature of Signing Officer or Director

PDT

12/05/2011

\_\_\_\_\_  
Date