

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

FILED

02 DEC 26 PM 2:53

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

CORPORATION
REINSTATEMENT



FLORIDA DEPARTMENT OF STATE

Jim Smith

Secretary of State

DIVISION OF CORPORATIONS

DOCUMENT # H89768

1. Corporation Name

Healthcare Alternatives of West
Florida, Inc.

300009690079
12/26/02--01035--003 **150.00

2. Principal Office Address

1555 S. Ft. Harrison

Suite, Apt. #, etc.

3. Mailing Office Address

1555 S. Ft. Harrison

Suite, Apt. #, etc.

City & State

Clearwater, FL

City & State

Clearwater, FL

Zip

33756

Country

Pinellas

Zip

33756

Country

Pinellas

4. Date Incorporated or Qualified
To Do Business in Florida

12-12-85

5. FEI Number

59-2625969

Applied For

Not Applicable

6. CERTIFICATE OF STATUS DESIRED ☒

\$8.75 Additional Fee required
for a Certificate of Status

7. Name and Address of Current Registered Agent

Name

M.K. El-Yousef, M.D.

Street Address (P.O. Box Number is Not Acceptable)

1555 S. Ft. Harrison

Suite, Apt. #, Etc.

City

Clearwater

State

FL

Zip Code

33756

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

Signature of

Registered Agent

Date

REGISTERED AGENT MUST SIGN

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	Street Address of Each Officer and/or Director	City / State / Zip
Pres & Treas	M.K. El-Yousef, M.D.	1555 S. Ft. Harrison	Clearwater, FL 33756

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 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 AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

12-23-02

12/30

CR2E081 (9/01)

Health Care Alternatives of Florida, Inc.
1555 S. Ft. Harrison Ave.
Clearwater, FL 33756

Health Care Alternatives of Florida, Inc

December 19, 2002

Department of State
Division of Corporations
PO Box 6327
Tallahassee, FL 32314

Re: Annual Report Filing Tax ID# 59-2625969

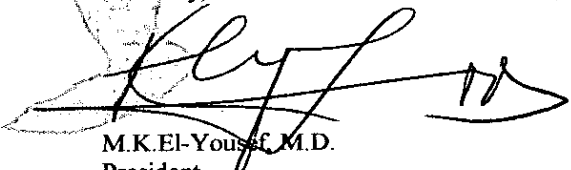
To whom it may concern;

Please be advised that we never received an annual report form for our company, due to the fact that we relocated the office to the above address. We found out about the matter only today.

We are asking that the fee be waived due to these circumstances.

Thank you for your cooperation in this matter.

Sincerely,



M.K. El-Youssef, M.D.
President