

**APPLICATION
FOR
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE
Sandra B. Mortham
Secretary of State
DIVISION OF CORPORATIONS

J87415

**FILED
99 JUN 17 PH 1:14
SECRETARY OF STATE
TALLAHASSEE, FLORIDA**

DOCUMENT # **J87415**

1. Corporation Name
Healthcare Management Resources, Inc.

Principal Place of Business 8695 College Parkway Suite 301 Ft. Myers, FL 33919	Mailing Address 8695 College Parkway Suite 301 Ft. Myers, FL 33919
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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		4. Date Incorporated or Qualified To Do Business in Florida	
Suite, Apt. #, etc.		Suite, Apt. #, etc.		08/17/87	
City & State		City & State		5. FEI Number	
Zip		Country		58-1272943	
				6. CERTIFICATE OF STATUS DESIRED <input type="checkbox"/>	
				58.75 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 (Do NOT Use Post Office Box Numbers)	4. City / State / Zip
P/D	Mary G. Bowman	8695 College Parkway, #301	Ft. Myers, FL 33919
			800002914988--9 -06/24/99--01101--030 ***1922.50 ***1922.50

**REINSTATEMENT 90-99
cc**

8. Name and Address of Current Registered Agent		9. Name and Address of New Registered Agent	
Mary Bowman McColgan 8695 College Parkway Suite 301 Ft. Myers, FL 33919		Name Street Address (P.O. Box Number is Not Acceptable) Suite, Apt. #, Etc. City State Zip Code FL	

10. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of Section 807.0505, F.S.
Signature of Registered Agent BY: *Mary G. Bowman* Date: *6/14/99*
REGISTERED AGENT MUST SIGN

11. This corporation owes or has paid the current year Intangible Personal Property tax due June 30. Yes No (See other side for information on intangible tax.)

12. I certify that I am an officer or director or the receiver or trustee empowered to execute this application as provided for in chapter 807 or 817, 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 807.0401 or 817.0401, 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: *MARY G. BOWMAN* *Mary G. Bowman* 6/14/99
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #
404/329-9314

CR2020 (1/99)

Document Number Only

CT Corporation System
660 East Jefferson Street
Tallahassee, FL 32301
Tel 850 222 1092
Fax 850 222 7615
Attn: Jeff Netherton

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TALLAHASSEE, FLORIDA

CORPORATION(S) NAME

Healthcare Management Resources, Inc.

- | | | |
|--|--|---|
| <input type="checkbox"/> Profit | <input type="checkbox"/> Amendment | <input type="checkbox"/> Merger |
| <input type="checkbox"/> Nonprofit | | |
| <input type="checkbox"/> Foreign | <input type="checkbox"/> Dissolution/Withdrawal
<input checked="" type="checkbox"/> Reinstatement | <input type="checkbox"/> Mark |
| <input type="checkbox"/> Limited Partnership | <input type="checkbox"/> Annual Report | <input type="checkbox"/> Other |
| <input type="checkbox"/> LLC | <input type="checkbox"/> Name Registration | <input type="checkbox"/> Change of RA |
| | <input type="checkbox"/> Fictitious Name | <input type="checkbox"/> UCC |
| <input type="checkbox"/> Certified Copy | <input type="checkbox"/> Photocopies | <input type="checkbox"/> CUS |
| <input type="checkbox"/> Call When Ready | <input type="checkbox"/> Call If Problem | <input type="checkbox"/> After 4:30 |
| <input checked="" type="checkbox"/> Walk In | <input type="checkbox"/> Will Wait | <input checked="" type="checkbox"/> Pick Up |
| <input type="checkbox"/> Mail Out | | |

Name _____
Availability _____
Document _____
Examiner _____
Updater _____
Verifier _____
Acknowledgement _____
W.P. Verifier _____

06/17/99

FILE FIRST

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