

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

FILED

**CORPORATION
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

03 MAY 30 AM 9:42

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # K38769

1. Corporation Name

Schillinger and Schorr MD.P.A.

2. Principal Office Address
13005 Southern Blvd

3. Mailing Office Address
13005 Southern Blvd

REINSTATEMENT 01-03

Suite, Apt. #, etc.
mm II #224

Suite, Apt. #, etc.
mm II #224

City & State
Loxahatchee, FL

City & State
Loxahatchee, FL

Zip Country
33470 U.S.A.

Zip Country
33470 USA

4. Date Incorporated or Qualified
To Do Business in Florida 10/14/88

5. FEI Number 650080090

6. CERTIFICATE OF STATUS DESIRED ☒ \$8.75 Additional Fee for a Certificate

7. Name and Address of Current Registered Agent 800020261538

Name M. Gary Schorr M.D. 05/30/03--01004--009 **1098.75

Street Address (P.O. Box Number is Not Acceptable)
13005 Southern Blvd mm II #224

Suite, Apt. #, Etc.

City Loxahatchee State FL Zip Code 33470

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 M. Gary Schorr M.D.

Date 5/27/03

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
V.P.	M. Gary Schorr	13005 Southern Blvd mm II #224	Loxahatchee, FL 33470
P.	Brent Schillinger	13005 Southern Blvd mm II #224	Loxahatchee, FL 33470

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 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 is 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 on this application is true and accurate, and my signature shall have the same legal effect as if made under oath.

SIGNATURE:

M. Gary Schorr M.D.

Date

5/27/03 561 7932929

Daytime Phone #

5/6/2