

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

FILED

02 APR 26 PM 1:27

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

**CORPORATION  
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE  
**Katherine Harris**  
Secretary of State  
DIVISION OF CORPORATIONS

700005492837--2  
-05/09/02--01001--007  
\*\*\*1315.00 \*\*\*1315.00

DOCUMENT # *K 46215*

1. Corporation Name  
*ATLANTIC ANESTHESIA ASSOCIATES INC.*

2. Principal Office Address  
*655 Seville CT*

3. Mailing Office Address  
*655 Seville CT*

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State  
*Satellite Beach, FL*

City & State  
*Satellite Beach, FL*

4. Date Incorporated or Qualified  
To Do Business in Florida *NOV. 17, 1988*

5. FEI Number  
*65-0089556*

Applied For  
Not Applicable

Zip Country  
*32937 Brevard*

Zip Country  
*32937 Brevard*

6. CERTIFICATE OF STATUS DESIRED  \$8.75 Additional Fee required  
for a Certificate of Status

7. Name and Address of Current Registered Agent

Name  
*HELEN BEIRNE*

Street Address (P.O. Box Number is Not Acceptable)  
*655 Seville CT*

Suite, Apt. #, Etc.

City  
*Satellite Beach, FL*

State Zip Code  
**FL** *32937*

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  
*Helen Beirne*

Date *4-11-02*

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
<i>PRESIDENT</i>	<i>HELEN BEIRNE</i>	<i>655 Seville CT</i>	<i>Satellite Beach, FL 32937</i>

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: *Helen Beirne (HELEN BEIRNE)*  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date *4-11-02* Daytime Phone # *321-779-1330*

CR2E081 (9/01)

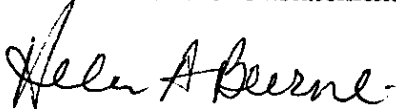
April 11, 2002

FLORIDA DEPARTMENT OF STATE  
DIVISION OF CORPORATIONS  
P.O. BOX 6327  
TALLAHASSEE, FL 32314

SUBJECT: REINSTATEMENT OF ATLANTIC ANESTHESIA ASSOCIATES, INC.  
Ref. Number: K46215

Pursuant to our conversation of April 1, 2002, I am submitting the following letter to assist in the reinstatement of ATLANTIC ANESTHESIA ASSOCIATES, INC.

ATLANTIC ANESTHESIA ASSOCIATES, INC. moved from Miami, Fl in August 1994. Since that time we have received no notices or Uniform Business Reports of any kind. Please find a check in the amount of \$1315.00 for the reinstatement fees.



Helen A. Beirne  
President