

2004 FOR PROFIT CORPORATION REINSTATEMENT

DOCUMENT # K97469 1. Entity Name ASSOCIATES OF PULMONARY AND CRITICAL CARE MEDICINE, P.A.					
Principal Place of Business 60 WEST COLUMBIA ST., SUITE F ORLANDO, FL 32806			Mailing Address P O BOX 560364 ORLANDO, FL 32856 US		
2. Principal Place of Business Suite, Apt. #, etc.		3. Mailing Address Suite, Apt. #, etc.			
City & State		City & State			
Zip	Country	Zip	Country		
6. Name and Address of Current Registered Agent VARRAUX, ALAN R 6139 GREATWATER DRIVE WINDERMERE, FL 34786				7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) City FL Zip Code	
8. 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. I am familiar with, and accept the obligations of registered agent.					
SIGNATURE _____ <small>Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE</small>					
FILE NOW!!! FEE IS \$750.00 After January 1, 2005, Fee will be \$900.00					
10. OFFICERS AND DIRECTORS			11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	P <input type="checkbox"/> Delete VARRAUX, ALAN R 6139 GREATWATER DRIVE WINDERMERE, FL 34786		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition 500043043385 11/29/04--01060--008 **750.00	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
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TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition	
12. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(i), Florida Statutes. I further certify that the information indicated on this report or supplemental report is true and accurate and that my 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 in Block 10 or Block 11 if changed, or on an attachment with an address, with all other like empowered.					
SIGNATURE:			11/24/04 407-841-0084		
<small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR</small>			<small>Date Daytime Phone #</small>		

FILED

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SECRETARY OF STATE
TALLAHASSEE, FLORIDA



REINSTATEMENT 2004

4. FEI Number **59-2892305** Applied For ☐ Not Applicable ☐

5. Certificate of Status Desired ☐ **\$8.75 Additional Fee Required**