

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

**LIMITED LIABILITY
COMPANY
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

SECRETARY OF STATE
DIVISION OF CORPORATIONS

08 APR 21 PM 3:39

DOCUMENT # L04000094437

1. Limited Liability Company's Name

Advanced Practice Clinic, L.L.C.

300124821933
04/21/08--01013--020 **521.25

CR2E041 (12/07)

2. Principal Office Address - No P.O. Box #

443 Shoemaker Drive

Suite, Apt. #, etc.

3. Mailing Office Address

P.O. Box 184

Suite, Apt. #, etc.

City & State

DeFuniak Springs, FL

City & State

DeFuniak Springs, FL

Zip 32433

Country USA

Zip 32435

Country USA

4. State/Country of Formation

Florida / USA

5. Date Organized or Qualified
To Do Business in Florida

Dec. 30, 2004

6. FEI Number

861121307

Applied For

Not Applicable

7. CERTIFICATE OF STATUS DESIRED ☒

\$5.00 Additional Fee required
for a Certificate of Status

8. Name and Address of Current Registered Agent

Name Jill M. Allen

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

443 Shoemaker Drive

Suite, Apt. #, Etc.

City DeFuniak Springs

State FL

Zip Code 32433

☐ A \$100 reinstatement fee is imposed, except
in circumstances which the entity did not
receive the prior notices. By checking this
box, you are certifying the prior notices were
not received and requesting the \$100
reinstatement be waived.

9. I, being appointed the registered agent of the above named limited liability company, am familiar with and accept the obligations of Chapter 608, F.S.

Signature of
Registered Agent

Jill M. Allen
REGISTERED AGENT MUST SIGN

Date

4/17/08

10. Names and Street Addresses of Managing Members/Managers

Titles	Name of Managing Members/Managers	Street Address of Each Managing Member/Manager	City / State / Zip
MEM	Jill M. Allen	443 Shoemaker Drive	DeFuniak Springs, FL 32433

REINSTATEMENT 2006-08

11. I certify that I am managing member/manager or the receiver or trustee empowered to execute this application as provided for in chapter 608, F.S. I further certify that when filing this reinstatement application the reason for dissolution has been eliminated, the limited liability company name satisfies the requirements of section 608.406, F.S., and that all fees owed by the limited liability company have been paid. 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 of
Managing Member/Manager

Jill M. Allen

Date

4/17/08

Daytime Phone #

850-225-9811

Typed or printed name of signing Managing Member/Manager