

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

LIMITED LIABILITY  
COMPANY  
REINSTATEMENT



FLORIDA DEPARTMENT OF STATE  
Secretary of State  
DIVISION OF CORPORATIONS

FILED  
SECRETARY OF STATE  
DIVISION OF CORPORATIONS

10 MAY -3 AM 10:39

DOCUMENT # L08000044753

1. Limited Liability Company's Name

GI ASSOCIATES OF BREVARD, LLC

400176888434  
04/21/10--01028--003 \*\*382.50

CR2E041 (11/09)

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

1004 BEVERLY DRIVE

Suite, Apt. #, etc.

SUITE B

City & State

ROCKLEDGE, FL

Zip

32955

Country

USA

3. Mailing Office Address

110 LONGWOOD AVENUE

Suite, Apt. #, etc.

City & State

ROCKLEDGE, FL

Zip

32955

Country

USA

4. State/Country of Formation

FLORIDA, USA

5. Date Organized or Qualified  
To Do Business in Florida

5-5-08

6. FEI Number

26-2540320

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

WNESTHOFF FAMILY PHYSICIANS, INC

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

110 LONGWOOD AVENUE

Suite, Apt. #, Etc.

City

ROCKLEDGE

State

FL

Zip Code

32955

☐ 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

*[Signature]*

REGISTERED AGENT MUST SIGN

Date

4/15/10

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
MEMBER	WNESTHOFF FAMILY PHYSICIANS,	110 LONGWOOD AVENUE	ROCKLEDGE, FL 32955

REINSTATEMENT 2009-10 SEM

11. E-mail Address: LYNDA.KIRKLAND@WNESTHOFF.ORG

(To be used for future annual report notifications)

12. 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

*[Signature]*

Date

4/15/10

Daytime Phone #

321-636-2211

Typed or printed name of signing Managing Member/Manager

EMIL MILLER, CEO