

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM

**LIMITED LIABILITY
COMPANY
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

2016 NOV -4 AM 4:50

DOCUMENT # L15000072970

1. Limited Liability Company's Name

C. Crawford Consulting LLC

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

1943 Massachusetts Ave NE

3. Mailing Office Address

1943 Massachusetts Ave NE

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

St. Petersburg, FL

City & State

St. Petersburg, FL

Zip

33703

Country

USA

Zip

33703

Country

USA

CR2E041 (1/14)

4. State/Country of Formation

FL

5. Date Organized or Qualified To Do Business in Florida

4/24/2015

6. FEI Number

47-3911059

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 Colleen M. Crawford

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

1943 Massachusetts Ave NE

Apt. #, Etc.

City

St. Petersburg

State

FL

Zip Code

33703

300281888143
11/04/16--01017--025 **238.75

9. I, being appointed the registered agent of the above named limited liability company, am familiar with and accept the obligations of Chapter 605, F.S.

Signature of Registered Agent

Colleen M Crawford

Date 11/2/2016

REGISTERED AGENT MUST SIGN

10. Names and Street Addresses of Authorized Representatives/Managers

| Titles | Name of Authorized Representatives/Managers | Street Address of Each Authorized Representative/Manager | City / State / Zip |
|----------------------|---|--|---------------------------------|
| Manager | <u>Colleen M. Crawford</u> | <u>1943 Massachusetts Ave NE</u> | <u>St. Petersburg, FL 33703</u> |
| REINSTATEMENT | | | |
| | <u>2016</u> | | |
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11. E-mail Address: colleenmccrawford@verizon.net

(To be used for future annual report notifications)

12. I certify that I am an authorized representative/ manager or the receiver or trustee empowered to execute this application as provided for in Chapter 605, 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 requirement of section 605.0012, 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. I am aware that false information submitted in a document to the Department of State constitutes a third degree felony as provided for in s. 817.155, F.S.

Signature of authorized representative/member

Colleen M Crawford 11/2/2016

Date

Daytime Phone #

727-432-0088

Typed or printed name of signing authorized representative/member

Colleen M Crawford

NOV - 4 2016