1/02

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

FILED
02 SEP 10 PM 4:09
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

CORPORATION REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Jim Smith
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # L31465

1. Corporation Name

Health Care Associates of Brevard, Inc.

REINSTATEMENT 01-02

2. Principal Office Address		3. Mailing Office Address	
1663 Georgia Street		1663 Georgia Street	
Suite, Apt. #, etc. Suite 700		Suite, Apt. #, etc. Suite 700	
City & State Palm Bay, FL		City & State Palm Bay, FL	
Zip 32907	Country USA	Zip 32907	Country USA

4. Date Incorporated or Qualified To Do Business in Florida 11/20/89

5. FEI Number 592976576 — Applied For / Not Applicable

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

7. Name and Address of Current Registered Agent

Name: James M. O'Brien

Street Address (P.O. Box Number is Not Acceptable): 1686 W. Hibiscus Blvd.

Suite, Apt. #, Etc.

City: Melbourne — State: FL — Zip Code: 32901

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 _____ REGISTERED AGENT MUST SIGN — Date 9/5/02

CR2E085 (8/01)

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
D	James J. Bradstreet	730 Emerson Drive	Palm Bay, FL 32907
D	Peter W. Taraschi	730 Emerson Drive	Palm Bay, FL 32907
D	Morgan R. Bunch	730 Emerson Drive	Palm Bay, FL 32907
D	Lori D. Bradstreet	730 Emerson Drive	Palm Bay, FL 32907

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: _____ 321-953-0278

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

Florida Department of State
Division of Corporations
Public Access System

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To:
Division of Corporations
Fax Number : (850)205-0384

From:
Account Name : O'BRIEN, RIEMENSCHNEIDER, KANCILIA & LEMONIDIS, P.A.
Account Number : 105204000476
Phone : (321)728-2800
Fax Number : (321)728-0002

CORPORATION REINSTATEMENT

HEALTH CARE ASSOCIATES OF BREVARD, INC.

Certificate of Status	1
Certified Copy	0
Page Count	01
Estimated Charge	$908.75