1 of 2

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

FILED
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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

CR2E081 (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 #

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Florida Department of State
Division of Corporations
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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