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Audit No. (((H04000078791 3)))

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SECRETARY OF STATE
TALLAHASSEE, FLORIDA

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

CORPORATION REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # L31465

1. Corporation Name

HEALTH CARE ASSOCIATES OF BREVARD, INC.

2. Principal Office Address	3. Mailing Office Address
1688 West Hibiscus Blvd.	1688 West Hibiscus Blvd.
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State: Melbourne, FL	City & State: Melbourne, FL
Zip: 32901 / Country: USA	Zip: 32901 / Country: USA

REINSTATEMENT 05-04

4. Date Incorporated or Qualified To Do Business in Florida: 11/20/1989

5. FEI Number: 59-2976576 — 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 West 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 _____ Date 4/16/2004

REGISTERED AGENT MUST SIGN

CR2E081 (01/04)

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
DPST	James J. Bradstreet	1688 West Hibscus Blvd.	Melbourne, FL 32901

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: _____ Date _____ Daytime Phone # 321-953-0278

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

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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
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