1052

Audit No. (((H04000078791 3)))

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

FILED
04 APR 19 AM 9:24
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

CORPORATION REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # L31465

1. Corporation Name

HEALTH CARE ASSOCIATES OF BREVARD, INC.

REINSTATEMENT 0509

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

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

CR2E061 (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 321-953-0278

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

BB

Florida Department of State
Division of Corporations
Public Access System

Electronic Filing Cover Sheet

Note: Please print this page and use it as a cover sheet. Type the fax audit number (shown below) on the top and bottom of all pages of the document.

(((H040000078791 3)))

Note: DO NOT hit the REFRESH/RELOAD button on your browser from this page. Doing so will generate another cover sheet.

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

Electronic Filing Menu Corporate Filing Public Access Help