

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION  
FOR  
REINSTATEMENT



FLORIDA DEPARTMENT OF STATE  
Katherine Harris  
Secretary of State  
DIVISION OF CORPORATIONS

FILED  
SECRETARY OF STATE  
DIVISION OF CORPORATIONS

DOCUMENT # L65721

1. Corporation Name

MEDICAL EQUITIES PARTNERS, INC.

00 NOV -7 AM 10:35

Principal Place of Business

1802 LARGO ROAD  
JACKSONVILLE FL 32207

Mailing Address

1802 LARGO RD  
JACKSONVILLE FL 32207

If above addresses are incorrect in any way, line through incorrect information and enter correction below.

2. New Principal Office Address, If Applicable

3. New Mailing Office Address, If Applicable

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Zip

Country

Zip

Country

4. Date Incorporated or Qualified  
To Do Business in Florida

04/16/1990

5. FEI Number

59-3075130

Applied For

Not Applicable

6. CERTIFICATE OF STATUS DESIRED ☐

\$8.75 Additional Fee required  
for a Certificate of Status

7. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at least 3 directors)

1 Title(s)	2 Name of Officers and/or Directors	3 Street Address of Each Officer and/or Director	4 City / State / Zip
DPS	LEWIS, BRETT J.	1802 LARGO RD	JACKSONVILLE FL 32207
T	LEWIS, BRETT J.	4651 SALISBURY RD STE 155	JACKSONVILLE FL 900002491069--6 -12/08/00--01010--013 ****785.00 ****785.00

8. Name and Address of Current Registered Agent

9. Name and Address of New Registered Agent

Name

Brett J. Lewis

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

1802 Largo rd

Suite, Apt. #, Etc.

City

JAX FL

State

Zip Code

FL

32207

10. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of Section 607.0505, F.S.

Signature of  
Registered Agent

**SIGNATURE REQUIRED**  
REGISTERED AGENT MUST SIGN

Date

10/29/00

11. 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:

**SIGNATURE REQUIRED**  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

10/29/00

AD