PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT 02 MAR

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

FILED
02 OCT 28 PM 3:57
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # L78961

1. Corporation Name

STEVEN A. REID, M.D., P.A.

Principal Place of Business	Mailing Address
4881 NW 8 AVE SUITE 5 GAINESVILLE FL 32605 US	4881 NW 8 AVE SUITE 5 GAINESVILLE FL 32605 US

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: 06/04/1990

5. FEI Number: 59-3015929 ☐ 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)

Title(s) 1	Name of Officers and/or Directors 2	Street Address of Each Officer and/or Director 3	City / State / Zip 4
D	REID, STEVEN A. M.D.	4881 NW 8TH AVE, SUITE 5	GAINESVILLE FL 32605

900008629709
10/28/02--01104--002 **150.00

8. Name and Address of Current Registered Agent

REID, STEVEN A., MD
4881 NW 8 AVE, SUITE 5
GAINESVILLE FL 32605

9. Name and Address of New Registered Agent

Name

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

Suite, Apt. #, Etc.

City | State: FL | Zip Code

CR2E040 (8/02)

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. or 617.0505, F.S.

without prejudice

Signature of Registered Agent: SIGNATURE REQUIRED
REGISTERED AGENT MUST SIGN

Date: 10/22/02

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.

without prejudice

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

Date: 10/22/02

Daytime Phone #: 352 3327246

STEVEN A. REID, M.D., F.A.C.S
Neurological Surgery

October 22, 2002

Division of Corporations
Annual Report/Reinstatement Section
Post Office Box 6327
Tallahassee, FL 32314-6327

To Whom It May Concern:

The purpose of this correspondence is in response to the application for reinstatement received on October 21, 2002. As of this date, the prior UBR notices have not been received in my office.

I therefore respectfully request that the reinstatement fee be waived and my corporation be reinstated. I have enclosed the application for reinstatement and the fee of $150.00.

Should there be a problem with this request or if you require further information, please feel free to contact my office manager, Jacki Kilgo, at (352) 332-7246. Thank you for your assistance and cooperation in this matter.

Sincerely,

Steven A. Reid, MD
Neurosurgery