

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION



FLORIDA DEPARTMENT OF STATE

Jim Smith

Secretary of State

DIVISION OF CORPORATIONS

REINSTATEMENT

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

4881 NW 8 AVE
SUITE 5
GAINESVILLE FL 32605
US

Mailing Address

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

Suite, Apt. #, etc.

City & State

Zip

Country

3. New Mailing Office Address, If Applicable

Suite, Apt. #, etc.

City & State

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

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.

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.

SIGNATURE:

SIGNATURE REQUIRED

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

10/22/02 352
3327246

CR2E040 (8/02)

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

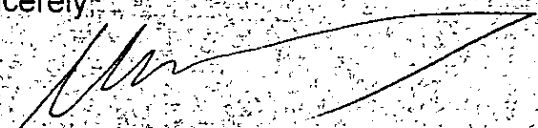
To Whom It May Concern:

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