

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

FILED

02 APR 29 PM 2:39

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

000005493220--7  
-05/09/02--01008--007  
\*\*\*\*122.50 \*\*\*\*122.50

**CORPORATION  
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE

Katherine Harris  
Secretary of State

DIVISION OF CORPORATIONS

**DOCUMENT #**

1. Corporation Name *Charlotte County medical  
managers Assoc. Inc*

*N00000002903*

**2. Principal Office Address**

*2421 Shreve St #113*

Suite, Apt. #, etc.

**3. Mailing Office Address**

*2421 Shreve St*

Suite, Apt. #, etc.

*#113*

**City & State**

*Punta Gorda FL*

Zip

*33950*

Country

*USA*

**City & State**

*Punta Gorda FL*

Zip

*33950*

Country

*USA*

**4. Date Incorporated or Qualified  
To Do Business in Florida**

*5-1-2000*

**5. FEI Number**

*65-1015581*

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

*ALLMED Financial Services Inc (MARY HARFST)*

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

*2421 Shreve St #113*

Suite, Apt. #, Etc.

City

*Punta Gorda*

State  
**FL**

Zip Code

*33950*

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

*M. Harfst*

Date *4-25-2002*

REGISTERED AGENT MUST SIGN

**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
<i>Pres</i>	<i>Brenda Bundy</i>	<i>617 W. Olympia Ave</i>	<i>Punta Gorda FL 33950</i>
<i>Sec</i>	<i>Shirley</i>	<i>28007 N. Twin Lakes Dr</i>	<i>Punta Gorda FL 33955</i>
<i>Treas</i>	<i>MARY HARFST</i>	<i>1626 ALBATROSS DR</i>	<i>Punta Gorda FL 33950</i>

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:

*M. Harfst*

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

*4-25-2002 941-639-5200*

Date

Daytime Phone #

CR2E081 (9/01)

April 24, 2002

Florida Dept of State  
DIVISION OF CORPORATIONS  
PO BOX 6327  
Tallahassee, FL 32314

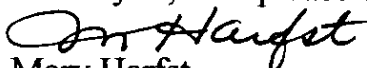
RE: Reinstatement of "Non Profit" Corporation  
NON RECEIPT OF NOTICE

Dear Sirs:

Enclosed is our check #1003 in the amount of \$122.50 for 2001 and 2002.  
We failed to pay this because the mail was not forwarded to my new  
address. Therefore, we did not receive any notices to pay the annual fee.

Please Re-instate our Non Profit Corporation # N00000002903 which began  
May 1, 2000.

Thank you, and please change our address.

  
Mary Harfst  
Treasurer

DEPARTMENT OF THE TREASURY  
INTERNAL REVENUE SERVICE  
ATLANTA GA 39901

DATE OF THIS NOTICE: 06-19-2000  
NUMBER OF THIS NOTICE: CP 575 F  
EMPLOYER IDENTIFICATION NUMBER: 65-1015581  
FORM: SS-4  
0716830481 0

CHARLOTTE COUNTY MEDICAL MANAGEMENT  
% MARY HARFST  
251 OLYMPIA AVE 4  
PUNTA GORDA FL 33950

FOR ASSISTANCE CALL US AT:  
1-800-829-1040

OR WRITE TO THE ADDRESS  
SHOWN AT THE TOP LEFT.

IF YOU WRITE, ATTACH THE  
STUB OF THIS NOTICE.

WE ASSIGNED YOU AN EMPLOYER IDENTIFICATION NUMBER (EIN)

Thank you for your Form SS-4, Application for Employer Identification Number (EIN). We assigned you EIN 65-1015581. This EIN will identify your business account, tax returns, and documents, even if you have no employees. Please keep this notice in your permanent records.

Use your complete name and EIN as shown above on all federal tax forms, payments, and related correspondence. If you use any variation in your name or EIN, it may cause a delay in processing, incorrect information in your account, or cause you to be assigned more than one EIN.

Please use the label IRS provided when filing tax documents. If that isn't possible, you should use your EIN and complete name and address as shown below to identify your account and to avoid delays in processing.

CHARLOTTE COUNTY MEDICAL MANAGEMENT  
ASSOCIATION INC  
% MARY HARFST  
251 OLYMPIA AVE 4  
PUNTA GORDA FL 33950

If this information isn't correct, please correct it using page 2 of this notice. Return it to us at the address shown so we can correct your account.

If you want to apply to receive a ruling or a determination letter recognizing your organization as tax exempt, and have not already done so, you should file Form 1023/1024, Application for Recognition of Exemption, with the IRS Ohio Key District Office. Publication 557, Tax Exempt Status for Your Organization, is available at most IRS offices and has details on how you can apply.

Thank you for your cooperation.

829 3674  
1 800 TAX Form  
# 1023

370627- SHR RCV  
FORM 10 DAYS