

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION
FOR
REINSTATEMENT

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

DOCUMENT # N98000006457

1. Corporation Name

AGAPE COMMUNITY HEALTH CORPORATION

Principal Place of Business

22980 LYNX COURT
SORRENTO FL 32776

Mailing Address

PO BOX 433
SORRENTO FL 32776

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

11/09/1998

5. FEI Number

22-3615490

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	WILSON, AYANNA	22980 LYNX COURT	SORRENTO FL 32776
D	MITCHELL, RONALD	5919 TINTO LANE	ORLANDO FL 32822
D	EMILYN, MARK	32709 WOLF'S TRAIL	SORRENTO FL 32776

8. Name and Address of Current Registered Agent

WILSON, PATRICIA
22980 LYNX COURT
SORRENTO FL 32776

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

10/1/02

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

10/1/02

Date

Daytime Phone #

FILED

02 NOV -4 PM 5:42

SECRETARY OF STATE
TALLAHASSEE, FLORIDA



CR2040 (8/02)

October 30, 2002

Florida Department of State

Jim Smith
Secretary of State

Dear Jim Smith,

This is a request to waive the reinstatement fee for our corporation, Agape Community Health, FEI # 22-3615490 due to not receiving any prior uniform business report notices.

Thanks for your consideration.

Regards,

Patricia Wilson/Director