

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

phelotz

APPLICATION
FOR



FLORIDA DEPARTMENT OF STATE

Katherine Harris
Secretary of State

DIVISION OF CORPORATIONS

DOCUMENT # P00000007236

1. Corporation Name

UNITED GABLES OF TAMPA MEDICAL CENTER, INC.

Principal Place of Business

Mailing Address

1924 MARTIN LUTHER KING JR. BLVD.
TAMPA FL 33607

1924 MARTIN LUTHER KING JR. BLVD.
TAMPA FL 33607

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

01/24/2000

5. FEI Number

65097-5661

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
VD	GARI, LAZARO	1924 MARTIN LUTHER KING JR. BLVD	TAMPA FL 33607

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-12/05/01--01059--022
****150.00 ****150.00

8. Name and Address of Current Registered Agent

9. Name and Address of New Registered Agent

GARI, LAZARO
1924 MARTIN LUTHER KING JR. BLVD.
TAMPA FL 33607

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.

Signature of
Registered Agent

Date 10-26-01

REGISTERED AGENT MUST SIGN

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 AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

10-26-01 93-877-4439



United Gables Medical Center, Inc.

1924 W. M.L.K. Blvd.
Tampa, FL 33607

Dr. [Signature]

To whom it may concern:

I have not received any prior notices
of fees due, please accept my Application
with the fee of 150.00 as normal fee and
do not penalise me for not receiving your notice.

Thank You in advance
[Signature]