

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT
FLORIDA DEPARTMENT OF STATE
Tate Harris
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # P00000008084

1. Corporation Name

PODIATRIC MEDICAL CENTER, INC.

Principal Place of Business

Mailing Address

2828 E. COMMERCIAL BOULEVARD
FORT LAUDERDALE FL 33308

2828 E. COMMERCIAL BOULEVARD
FORT LAUDERDALE FL 33308

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

01/25/2000

5. FEI Number

65-0976025

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	DECUBELLIS, PHILLIP D	2828 E. COMMERCIAL BOULEVARD	FORT LAUDERDALE FL 33308

400004705604--5
-12/05/01--01028--017
****150.00 ****150.00

1/LS

8. Name and Address of Current Registered Agent

9. Name and Address of New Registered Agent

DECUBELLIS, PHILLIP D
2828 E. COMMERCIAL BOULEVARD
FORT LAUDERDALE FL 33308

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

SIGNATURE

Date

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 #

10/24/01 (954) 776-5700

CR2E040 (8/01)

ANKLE, FOOT & WOUND CARE ASSOCIATES

202

South Shore Hospital
600 Alton Road, #252
Miami Beach, FL 33139
(305) 672-2100, Ext. 3610

PHILLIP D. DeCUBELLIS, D.P.M., P.A.
Residency Director

DARYOUSH ZAFAR, D.P.M.
MIRTA HERNANDEZ, D.P.M.
SEAN LIFFITON, D.P.M.

2828 East Commercial Blvd.
Ft. Lauderdale, FL 33308
(954) 776-5700

October 24, 2001

Dept. of State
Division of Corporations
PO Box 6327
Tallahassee, FL 32314

RE: PODIATRIC MEDICAL CENTER, INC. – 65-0976025

Dear Sir or Madam:

The 2001 Annual Report from the Division of Corporations was never received by this corporation. We have no record of ever receiving said Annual Report, and therefore did not return the application.

Please find the Application for Reinstatement that WAS received by us, as well as a check for \$150.00 for the reinstatement fee.

Thank you for your consideration. If you have any questions, please do not hesitate to contact me.

Sincerely,



Phillip D. DeCubellis, DPM

PDD:ma

Enclosure