

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION
FOR
REINSTATEMENT



FLORIDA DEPARTMENT OF STATE
Glenda E. Hood
Secretary of State
DIVISION OF CORPORATIONS

FILED

03 OCT 13 PM 2:36

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # **P00000018763**

1. Corporation Name

SUMMER MEDICAL, INC.

Principal Place of Business

PO BOX 51496
JACKSONVILLE BEACH FL 32240

Mailing Address

PO BOX 51496
JACKSONVILLE BEACH FL 32240

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

02/18/2000

5. FEI Number

59-3625885

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	SCHILD, AUGUST F	PO BOX 51496	JACKSONVILLE BEACH FL 32240

500023750255
10/13/03--01066--021 **150.00

8. Name and Address of Current Registered Agent

SCHILD, AUGUST F
1717 RILEY ST.
JACKSONVILLE BEACH FL 32250

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

REGISTERED AGENT MUST SIGN

Date 10-10-03

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

AUGUST F. SCHILD 10-10-03 904-249-7360

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

CR2E040 (7/03)

SUMMER MEDICAL

P.O. Box 51496
Jacksonville Beach
Florida, 32240

Ph. 904-249-7360
Fax 904-249-1492
Mob. 904-607-3535

October 10, 2003

FLORIDA DEPARTMENT OF STATE

Glenda E. Hood
Secretary of State
Divisions Of Corporations

Dear Ms. Hood,

We are requesting a waiver of late fee for filing our UBR due to not receiving the renewal form.

We are unclear as to the reason the form was not received by us.

Enclosed is our check in the amount of \$150.00.

Thank you for considering this request.

Sincerely,

August F. Schild
Director

Fluidotherapy®

Ultrasound

Work Hardening

Dynasplint®

Exercise Equipment

Electrotherapy

Tables & Traction

Combination Therapy

