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 DEC 12 PM 12:44
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # **P00000022296**

1. Corporation Name

MED PLUS MEDICAL GROUP, INC.

Principal Place of Business	Mailing Address
2130 S TAMIAMI TRAIL SARASOTA FL 34239	PO BOX 25368 SARASOTA FL 34277

If above addresses are incorrect in any way, line through incorrect information and enter correction below.

REINSTATEMENT 03

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: 03/03/2000

5. FEI Number: 65-0999692 ☐ 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
D	KOMPOTHECRAS, GARY	738 EDGEMERE LN.	SARASOTA FL 34242

300025427823
12/11/03--01061--011 **150.00

8. Name and Address of Current Registered Agent	9. Name and Address of New Registered Agent
KOMPOTHECRAS, GARY 738 EDGEMERE LN. SARASOTA FL 34242	Name Street Address (P.O. Box Number is Not Acceptable) Suite, Apt. #, Etc. City / State: FL / Zip Code

CR2E040 (7/03)

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: Gary Kompothecras — Date: 12-1-03
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: Gary Kompothecras — GARY KOMPOTHECRAS — Date: 12-1-03 — Daytime Phone #: 941-924-8764

Med Plus Medical Group

P.O. Box 25368
Sarasota, FL 34277

December 4, 2003

Department of State

Division of Corporation
P.O. Box 6327
Tallahasee, FL 32314

Dear Sir or Madam:

Med Plus Medical Group never received the first UBR notice to file. We therefore request that the additional fee for late filing be waived. The $150.00 filing fee is enclosed.

Sincerely,

Dr. Gary Kompothecras
President