

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION



FLORIDA DEPARTMENT OF STATE

Katherine Harris

Secretary of State

DIVISION OF CORPORATIONS

REINSTATEMENT

FILED
SECRETARY OF STATE
DIVISION OF CORPORATIONS

01 OCT 15 AM 8:52

DOCUMENT # P00000035913

1. Corporation Name

CRITICAL CARE PROFESSIONALS OF FLORIDA, INC.

Principal Place of Business

Mailing Address

10242 N.W. 47TH AVE., SUITE 44
SUNRISE FL 33351

10242 N.W. 47TH AVE., SUITE 44
SUNRISE FL 33351



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

4. Date Incorporated or Qualified
To Do Business in Florida

04/07/2000

Suite, Apt. #, etc.

Suite, Apt. #, etc.

5. FEI Number

Applied For

City & State

City & State

65-0999803

Not Applicable

Zip

Country

Zip

Country

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
PSD	MILLER, JOSEPH K	10242 N.W. 47TH AVE., SUITE 44	SUNRISE FL 33351
T	MUSCOLINO, RICARDO	10242 N.W. 47TH AVE., SUITE 44	SUNRISE FL 33351
			200004653342-6 -10/25/01--01056--017 ****150.00 ****150.00

8. Name and Address of Current Registered Agent

9. Name and Address of New Registered Agent

MILLER, JOSEPH K
10242 N.W. 47TH AVE., SUITE 44
SUNRISE FL 33351

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 REQUIRED
REGISTERED AGENT MUST SIGN

Date

10/11/01

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

Date

10/11/01 (954)
742-7008

Daytime Phone #

CR2E040 (9/01)

October 11, 2001

Dept. of State
Division of Corporations
Uniform Business Report Filings
Reinstatement Dept.
P.O. Box 6327
Tallahassee, FL 32314

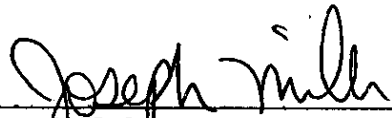
Re.: Critical Care Professionals of Florida, Inc.
F.E.I. No. 65-0999803
Dept. of State Document #: P00000035913

Dear Representative:

I have called your Reinstatement Department today October 11, 2001 at (850) 245-6059 and spoke to Ms. Leslie. I have explained to her that this is the first year of business for Critical Care Professionals of Florida, Inc., and that I never received the Uniform Business Report (UBR).

Ms. Leslie has instructed me to write this letter and filled-out the Application for reinstatement and send it in the enclosed envelope with a \$150.00 check to the Dept. of State. By executing, this letter, the revocation or dissolution of Critical Care Professionals of Florida, Inc. will not befall.

Sincerely,



Joseph K. Miller
President