

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 AM 8:43

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

DOCUMENT # **P00000062064**

1. Corporation Name

**ARMENIA SPINE CENTER, INC.**

Principal Place of Business

Mailing Address

3508 N. ARMENIA AVE  
TAMPA FL 33607

P.O. BOX 25368  
SARASOTA FL 34277

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

**REINSTATEMENT** 03



300025455203  
12/12/03--01040--008 \*\*150.00

4. Date Incorporated or Qualified  
To Do Business in Florida

06/26/2000

5. FEI Number

65-1020393

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)

Name of Officers  
and/or Directors

Street Address of Each  
Officer and/or Director

City / State / Zip

P

KOMPOTHECRAS, GARY

738 EDMERE LANE

SIESTA KEY FL 34242

8. Name and Address of Current Registered Agent

9. Name and Address of New Registered Agent

KOMPOTHECRAS, GARY  
738 EDMERE LANE  
SARASOTA FL 34242

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 12/1/03

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

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

GARY KOMPOTHECRAS

12/1/03

Date

941-924-8164

Daytime Phone #

CR2040 (7/03)

# Armenia Spine Center

P.O. Box 25368  
Sarasota, FL 34277

December 4, 2003

Department of State

Division of Corporation

P.O. Box 6327

Tallahassee, FL 32314

Dear Sir or Madam:

Armenia Spine Center, Inc. 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,

A handwritten signature in black ink, appearing to read "Gary Kompothecras", with a long horizontal flourish extending to the right.

Dr. Gary Kompothecras  
President