

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM

FILED

**CORPORATION
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE
Jim Smith
Secretary of State
DIVISION OF CORPORATIONS

02 DEC 18 AM 10:44

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT #

200000113971

1. Corporation Name

ASTAT HEALTHNETWORK CORP.

2. Principal Office Address

3. Mailing Office Address

15511 N FLORIDA AVE.
SUITE D
TAMPA FL

15511 N FLORIDA AVE.
SUITE D
TAMPA FL
33613 USA

33613 USA

Zip

Country

Zip

Country

REINSTATEMENT 02

4. Date Incorporated or Qualified
To Do Business in Florida

5. FEI Number

59-3686594

Applied For

Not Applicable

6. CERTIFICATE OF STATUS DESIRED ☐

\$8.75 Additional Fee required
for a Certificate of Status

7. Name and Address of Current Registered Agent

Name

ALAN J. IEZZI, MD
15511 N FLORIDA AVE.
SUITE D
TAMPA FL 33613

City

State
FL

Zip Code

8. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of section 607.0505 or 617.0503, F.S.

Signature of
Registered Agent

Alan J. Iezzi

REGISTERED AGENT MUST SIGN

Date 11/15/02

9. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at least 3 directors)

Titles	Name of Officers and/or Directors	Street Address of Each Officer and/or Director	City / State / Zip
PRESIDENT & SECRETARY	ALAN J. IEZZI, MD	15511 N FLORIDA AVE. SUITE D TAMPA FL 33613	
SHAREHOLDER	WILLIAM HUMPHRIES	15511 N FLORIDA AVE. SUITE D TAMPA FL 33613	
SHAREHOLDER	JOHN L. WOODS	15511 N FLORIDA AVE. SUITE D TAMPA FL 33613	

10. 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

ALAN J. IEZZI, MD - PRES. & SECY.

11/15/2002 (813) 908-8700 EXT.232

Date

Daytime Phone #

CR2E081 (9/01)