PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

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APPLICATION FOR REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Katherine Harris
Secretary of State
DIVISION OF CORPORATIONS

FILED
02 JAN 28 AM 8:39
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # **P01000001203**

1. Corporation Name

BAYSIDE MEDICAL AND REHABILITATION CENTER, INC.

Principal Place of Business	Mailing Address
1904 W MARTIN LUTHER KING BLVD TAMPA FL 33607	1904 W MARTIN LUTHER KING BLVD TAMPA FL 33607

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

4. Date Incorporated or Qualified To Do Business in Florida: 12/27/2000

5. FEI Number: 59-3691294 ☐ 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
PD	SALIVA, ELIZABETH	7515 N CLARK AVE	TAMPA FL 33614
VSD	SALVIA, BELKYS	4421 N ARMENIA AVE	TAMPA FL 33607
TD	SALVIA, ELIZABETH	7515 N CLARK AVE	TAMPA FL 33614
			300004911793--7 -02/12/02--01055--009 ****150.00 ****150.00
			300004911793--7 -02/12/02--01055--010 ****150.00 ****150.00

8. Name and Address of Current Registered Agent	9. Name and Address of New Registered Agent
SALVIA, ELIZABETH 7515 N CLARK AVE TAMPA FL 33614	Name Street Address (P.O. Box Number is Not Acceptable) Suite, Apt. #, Etc. City / State: FL / Zip Code

CR2E040 (8/01)

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 — Date: 11/02/01
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 REQUIRED — 11/02/01 — (813) 245-5041
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

BAYSIDE MEDICAL AND REHABILITATION CENTER , INC.

1904 W. Martin Luther King Blvd., Tampa, Florida 33607 (813) 874 - 9233 Fax 874 - 8532

December 3, 2001

Florida Department of State
Division of Corporations
P. O. Box 6327
Tallahassee, FL 32314

Enclosed is our annual report form and our check for $ 150.00. Our annual report was not filed timely because we did not receive a form and were unaware of the annual requirement. We respectfully request a waiver of the additional $ 600.00 reinstatement penalty.

Thank You.

Sincerely,

Elizabeth Salvia, President