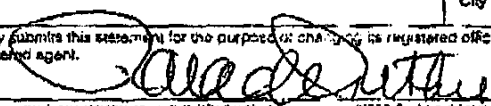
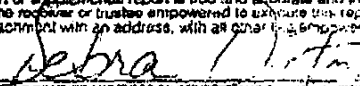


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05 OCT 18 PM 3: 05

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P01000044086			
1. Entity Name DERMA CLINIC OF NAPLES, INC.			
Principal Place of Business 814 ANCHOR BODE NAPLES, FL 34103		Mailing Address 530 SPINNAKER DR NAPLES, FL 34102	
2. Principal Place of Business		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country
4. FEI Number 59-3722561		Applied For Not Applicable	
5. Certificate of Status Desired ☐		\$8.75 Additional Fee Required	
6. Name and Address of Current Registered Agent RITCHIE, RONALD W 5129 CASTELLO DR STE 4 NAPLES, FL 34103		7. Name and Address of New Registered Agent	
Name		Street Address (P.O. Box Number is Not Acceptable)	
City		FL Zip Code	
8. The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. I am familiar with and accept the obligations of registered agent.			
SIGNATURE 		10/17/05	
Signature typed or printed name of registrant agent and the filer (if applicable)		(NOTE: Registered Agent signature required when reappointing)	
FILE NOW!!! FEE IS \$750.00 After January 1, 2006, Fee will be \$900.00			
10. OFFICERS AND DIRECTORS		11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D VICTOR, DEBRA L 530 SPINNAKER DR NAPLES, FL 34102 ☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Add
TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Add
TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Add
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TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Add
TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	☐ Change ☐ Add
12. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(i), Florida Statutes. I further certify that the information indicated on this report or supplemental report is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am an officer or director of the corporation or the receiver or trustee empowered to execute this report as required by Chapter 607, Florida Statutes; and that my name appears in Block 10 of this filing.			
SIGNATURE: 		10/17/05 239/201 9711	
Signature typed or printed name of signing officer or director		Date	

Florida Department of State
Division of Corporations
Public Access System

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((H05000246439 3)))

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Division of Corporations
Fax Number : (850) 205-0384

From:

Account Name : CORPORATION SERVICE COMPANY
Account Number : 120000000195
Phone : (850) 521-1000
Fax Number : (850) 558-1575

CORPORATION REINSTATEMENT

DERMA CLINIC OF NAPLES, INC.

Certificate of Status	0
Certified Copy	0
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