

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION  
FOR  
REINSTATEMENT



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

FILED

02 NOV 25 AM 9:39

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

DOCUMENT # P01000046929

1. Corporation Name

TREASURE COAST MEDICAL BILLING INC

Principal Place of Business

3049 SW ANN ARBOR RD.  
PORT ST. LUCIE FL 34953

Mailing Address

3049 SW ANN ARBOR RD.  
PORT ST. LUCIE FL 34953



100009198511  
11/25/02--01028--008 \*\*150.00

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

05/07/2001

Suite, Apt. #, etc.

Suite, Apt. #, etc.

5. FEI Number

65-111 7725

Applied For

Not Applicable

City & State

City & State

Zip

Country

Zip

Country

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	LESTER, CHRISTINE	3049 SW ANN ARBOR RD.	PORT ST. LUCIE FL 34953
V	LESTER, DANNY	3049 SW ANN ARBOR RD.	PORT ST. LUCIE FL 34953

8. Name and Address of Current Registered Agent

LESTER, CHRISTINE  
3049 SW ANN ARBOR RD.  
PORT ST. LUCIE FL 34953

9. Name and Address of New Registered Agent

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

*[Signature]*  
SIGNATURE REQUIRED

REGISTERED AGENT MUST SIGN

Date

11/19/02

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:

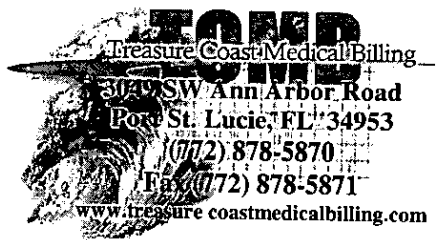
*[Signature]*  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

11/19/02 772-878-5870

CR20040 (8/02)



November 19, 2002

Division of Corporations  
Annual Report/Reinstatement Section  
P. O. Box 6327  
Tallahassee, FL 32314-6327

RE: Treasure Coast Medical Billing, Inc.

To Whom It May Concern:

I am requesting a waiver of the reinstatement fees for Treasure Coast Medical Billing, Inc. The enclosed notice is the first notice I have received.

I am attaching a check in the amount of \$150.00; please contact me if there are any concerns.

Thank you,

Christine Lester, CPC  
President  
Treasure Coast Medical Billing, Inc.

Enclosures