PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT 02 UCR

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	Mailing Address
3049 SW ANN ARBOR RD. PORT ST. LUCIE FL 34953	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	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country

4. Date Incorporated or Qualified To Do Business in Florida: 05/07/2001

5. FEI Number: 65-111 7725 ☐ 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
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

CR2E040 (8/02)

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 REQUIRED Date: 11/19/02

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 CHRISTINE LESTER 11/19/02 772-878-5870

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

Treasure Coast Medical Billing
3049 SW Ann Arbor Road
Port St. Lucie, FL 34953
(772) 878-5870
Fax (772) 878-5871
www.treasurecoastmedicalbilling.com

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