

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION
FOR



FLORIDA DEPARTMENT OF STATE

Jim Smith

Secretary of State

DIVISION OF CORPORATIONS

~~REINSTATEMENT~~

FILED

02 OCT 25 PM 3: 17

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P01000092942

1. Corporation Name

GLADES MEDICAL CARE CENTER INC

Principal Place of Business

927 S. E. FIRST STREET
BELLE GLADE FL 33430

Mailing Address

927 S. E. FIRST STREET
BELLE GLADE FL 33430

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

09/23/2001

5. FEI Number

☒ 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
CEO	MAIGNAN, MONISE M	8552 GULLANE COURT	WEST PALM BEACH FL 33412
COO	MAIGNAN, JEAN-EMILE R	8552 GULLANE COURT	WEST PALM BEACH FL 33412

9000008591749

10/25/02--01046--013 **150.00

8. Name and Address of Current Registered Agent

MAIGNAN, MONISE M
8552 GULLANE COURT
WEST PALM BEACH FL 33412

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 REQUIRED

REGISTERED AGENT MUST SIGN

Date

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.

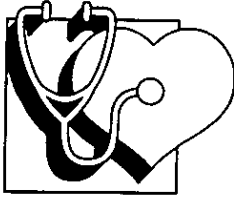
SIGNATURE:

SIGNATURE REQUIRED

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

10/21/02 (361) 996-4424
Date Daytime Phone #

CR2E040 (8/02)



Glades Medical Care Center, Inc.
Monise Maignan, M.D.
Internal Medicine

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DIVISION OF CORPORATION
ANNUAL REPORT/REINSTATEMENT SECTION
PO BOX-6327
TALLAHASSEE, FL 32314-6327

October 23, 2002

To Whom it may concern:

This letter is in regards to my application for reinstatement on behalf of Glades Medical care Center, Inc document # P01000092942. The corporation became official at the end of september 2001. This letter is to acknowledge a non receipt of any previous uniform business reports and application for reinstatement. The only form receive through our corporation was delivered on october 21st, 2002. Therefore, I would like to request a waiver pertaining to the reinstatement fee of \$600.00. I also would like to point out that our corporation is still very new, and such penalty although beyond our control will greatly hurt us financially. I will be sure from now on to look forward to the reinstatement application at the begining of every year in order to avoid any further penalties. Thank you for your prompt attention to this matter.

Sincerely,

Monise Maignan M.D.
Monise Maignan M.D.

10/23/02

Date