

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 20 AM 10:57

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

DOCUMENT # P01000107680

1. Corporation Name

TRI-CARE REHABILITATION, INC.

Principal Place of Business

2200 EAST IRLO BRONSON HWY. 192  
~~SUITE 107~~  
KISSIMMEE FL 34744

Mailing Address

2200 EAST IRLO BRONSON HWY. 192  
~~SUITE 107~~  
KISSIMMEE FL 34744

If above addresses are incorrect in any way, line through incorrect information and enter correction below.

2. New Principal Office Address, If Applicable

~~2200 EAST IRLO BRONSON HWY~~  
Suite, Apt. #, etc.

3. New Mailing Office Address, If Applicable

~~Suite 107~~  
Suite, Apt. #, etc.

4. Date Incorporated or Qualified  
To Do Business in Florida

11/07/2001

5. FEI Number

59-3760592

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
PTD	NELSON, MARYSE A	804 MENDOZA DRIVE	KISSIMMEE FL 34758

100009113381  
11/20/02--01068--016 \*\*150.00

8. Name and Address of Current Registered Agent

NELSON, MARYSE A  
804 MENDOZA DRIVE  
KISSIMMEE FL 34758

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

REGISTERED AGENT MUST SIGN

Date

11/02/02

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 AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

11/02/02 407-847-0900

CR2E040 (8/02)



## TRI-CARE REHABILITATION, INC.

2200 E IRLO BRONSON HWY., STE 103

KISSIMMEE, FL 34744

407-847-0900 FAX 407-847-0030 EMAIL [tricare@aol.com](mailto:tricare@aol.com)

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

November 02, 2002

To Whom It May Concern:

In response to the reinstatement package we received, this is to inform you that we never received your initial correspondence. I called your office and spoke with a representative who informed me that due to an address error, your initial letter was returned to you. I was advised to send this letter along with the 150 dollar fee in order to have my company reinstated.

Please note that the correct suite number for Tri-Care is #103 and not #107. I thank you in advance for your understanding and please do not hesitate to contact us with any questions.

Sincerely Yours,

Maryse A. Nelson, LPT, MBA  
Clinical Director