

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT



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

APPROVED AND FILED

DOCUMENT # **P01000108966**

1. Corporation Name

ST. MICHAEL MEDICAL CENTER, INC.

03 MAY -6 AM 9:24

Principal Place of Business

14940 W 49 PL STE 340
 HIALEAH FL 33012

Mailing Address

14940 W 49 PL STE 340
 HIALEAH FL 33012

JK

SECRETARY OF STATE
REINSTATEMENT 02-03



500014386915
 05/05/03--01096--026 **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

11/13/2001

Suite, Apt. #, etc.

Suite, Apt. #, etc.

5. FEI Number

Applied For

City & State

City & State

Not Applicable

01-0574081

Zip

Country

Zip

Country

- 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
D	LEMAIRE, JOSEPH M	14940 W 49 PL STE 340	HIALEAH FL 33012

500014386915
 03/20/03--01010--009 **750.00

8. Name and Address of Current Registered Agent

9. Name and Address of New Registered Agent

LEMAIRE, JOSEPH M
 14940 W 49 PL STE 340
 HIALEAH FL 33012

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 of Joseph M. Lemaire
SIGNATURE REQUIRED

REGISTERED AGENT MUST SIGN

Date

3/15/03

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 of Joseph M. Lemaire
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

3/15/03
 Date

(305) 535-1500
 Daytime Phone #

CR2040 (8/02)