

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM

FILED

2006 OCT 12 PM 3:33

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

**CORPORATION
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # P02000070184

1. Corporation Name

Senior Health Care of Volusia, P.A.

2. Principal Office Address

405 N. Clyde Morris Blvd.

Suite, Apt. #, etc.

City & State

Daytona Beach, FL

Zip
32114

Country
USA

3. Mailing Office Address

405 N. Clyde Morris Blvd.

Suite, Apt. #, etc.

City & State

Daytona Beach, FL

Zip
32114

Country
USA

REINSTATEMENT 05-06
CR2E081 (12/05)

**4. Date Incorporated or Qualified
To Do Business in Florida**

06/26/02

5. EFL Number

593666446

Applied For

Not Applicable

6. CERTIFICATE OF STATUS DESIRED ☒

\$8.75 Additional Fee required
for a Certificate of Status

7. Name and Address of Current Registered Agent

Name

Charles D. Hood, Jr.

Street Address (P.O. Box Number is Not Acceptable)

444 Seabreeze Blvd.

Suite, Apt. #, Etc.

Suite 900

City

Daytona Beach

State
FL

Zip Code
32118

100080744361

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8. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of section 607.0505 or 617.0503, F.S.

Signature of
Registered Agent

Date 10/10/06

REGISTERED AGENT MUST SIGN

9. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at least 3 directors)

Titles	Name of Officers and/or Directors	Street Address of Each Officer and/or Director	City / State / Zip
PD	Kenneth J. Lucas, M.D.	405 N. Clyde Morris Blvd.	Daytona Beach, FL 32114

10. 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 contained in Chapter 119, 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

Kenneth J. Lucas, M.D. 10/10/06

Date

386-257-1626

Daytime Phone #

10/16/06