PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

112

APPLICATION FOR REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Glenda E. Hood
Secretary of State
DIVISION OF CORPORATIONS

FILED
SECRETARY OF STATE
DIVISION OF CORPORATIONS
03 NOV 17 PM 4:12

DOCUMENT # **P02000074241**

1. Corporation Name

MEDICAL STAFF MANAGEMENT, INC.

Principal Place of Business	Mailing Address
10915 LYNDALE AVE. PORT RICHEY FL 34668	10915 LYNDALE AVE. PORT RICHEY FL 34668

REINSTATEMENT 03

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: 07/08/2002

5. FEI Number: 74-305-4425 ☐ 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)

Title(s) 1	Name of Officers and/or Directors 2	Street Address of Each Officer and/or Director 3	City / State / Zip 4
P	DANFORTH, KIMBERLEY C	10915 LYNDALE AVE.	PORT RICHEY FL 34668

400024764364
11/17/03--01103--015 **150.00

8. Name and Address of Current Registered Agent	9. Name and Address of New Registered Agent
SIIRA, STACY M 10915 LYNDALE AVE. PORT RICHEY FL 34668	Name Street Address (P.O. Box Number is Not Acceptable) Suite, Apt. #, Etc. City / State: FL / Zip Code

CR2E040 (7/03)

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: Stacy Siira Date:
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: Kimberly C Danforth 11-14-03 727-443-4443
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

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PRN NURSES

The Summit Building • 13575 58th St. N., Suite 102
Clearwater, FL 33760
Phone: 727-443-4443 • Fax: 727-538-4258

November 14, 2003

Department of State
Division of Corporations
P. O. Box 6327
Tallahassee, FL 32314

Re: Document #P02000074241 Medical Staff Management, Inc.

Gentlemen:

Please waive the reinstatement fee for the enclosed Application for Reinstatement as we never received the two uniform business report notices for 2003. We have completed the Application for Reinstatement and enclosed a check for $150.00. If there is any additional information needed, please contact me.

Sincerely,

Kimberley C. Danforth

Kimberley C. Danforth