

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION  
FOR  
REINSTATEMENT



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

FILED

04 JAN -2 PM 1:54

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

DOCUMENT # P02000077637

1. Corporation Name

WOODS HEALTHCARE GROUP, INC.

Principal Place of Business

Mailing Address

10 NORCROSS STREET STE 503  
ROSEWELL GA 30075

10 NORCROSS STREET STE 503  
ROSEWELL GA 30075

16 Norcross St.  
Ste 50-B

16 Norcross St  
Ste 50-B



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

07/17/2002

Suite, Apt. #, etc.

Suite, Apt. #, etc.

5. FEI Number

Applied For

City & State

City & State

35-2174932

Not Applicable

Zip

Country

Zip

Country

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
D	FLORY, MARY LOU	10 NORCROSS STREET STE 503 16 50-B	ROSEWELL GA 30007

500024797365  
11/18/03--01037--003 \*\*150.00

8. Name and Address of Current Registered Agent

9. Name and Address of New Registered Agent

MCKIBBEN, R. BRUCE JR  
1435 E PIEDMONT DRIVE STE 214  
TALLAHASSEE FL 32308

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

R. B. McKibben  
REGISTERED AGENT MUST SIGN

Date 11-17-03

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 AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

11-17-03

770.993.4000

Date

Daytime Phone #

**Woods Healthcare Group, Inc**

16 Norcross Street  
Suite 50-B  
Roswell, GA 30075  
Ph: 770-993-4000  
Fx: 770-993-9014

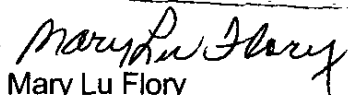
October 20, 2003

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

To Whom It May Concern:

The Notice of Administrative Dissolution or Revocation is the first notice that has been received regarding PalmWood Nursing Center. No prior Uniform Business Report was received. The mailing address was incorrect on the original UBR filed. Please waive the reinstatement fee. Thank you for your assistance.

Sincerely,



Mary Lu Flory  
Director

Woods Healthcare Group