## PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

# **APPLICATION FOR** REINSTATEMENT



### FLORIDA DEPARTMENT OF STATE

Glenda E. Hood Secretary of State

DIVISION OF CORPORATIONS

#### P02000104292 DOCUMENT #

1. Corporation Name

#### DELRAY MOBILE CLINIC INC.

Principal Place of Business

Mailing Address

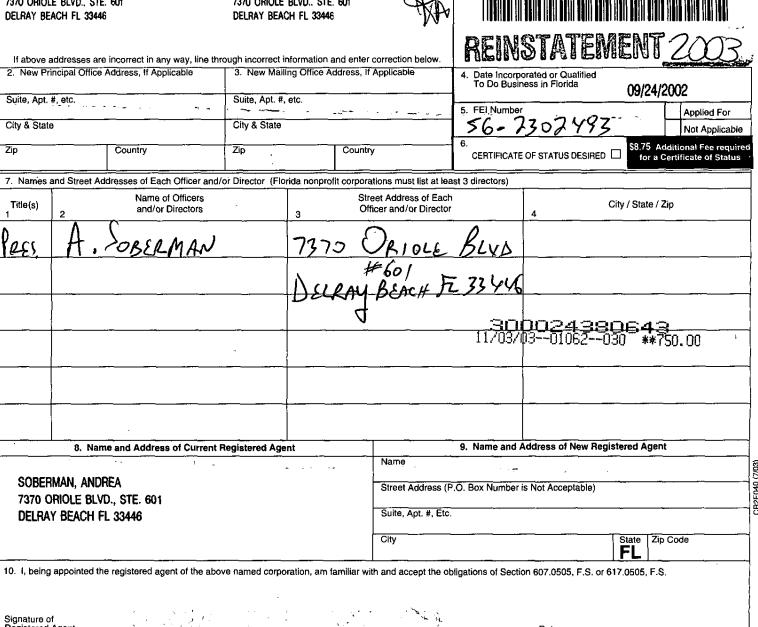
7370 ORIOLE BLVD., STE. 601

7370 ORIOLE BLVD., STE, 601



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SECRETARY OF STATE TALLAHASSEE, FLORIDA



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 filling 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 jegal effect as if made under oath.

OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Daytime Phone #