PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

CORPORATION REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

13 MAR -5 AM 9:41

DOCUMENT # P03000005401

1. Corporation Name

Naples Surgical Associates P.A.

REINSTATEMENT 10-13

CR2E081 (11/10)

2. Principal Office Address - No P O Box #	3. Mailing Office Address
311 9th Street North	808 Bentwood Drive
Suite, Apt #, etc: 308	Suite, Apt. #, etc:
City & State: Naples Florida	City & State: Naples Florida
Zip: 34102 Country: USA	Zip: 34108 Country: USA

4. Date Incorporated or Qualified To Do Business in Florida: 1-4-2003

5. FEI Number: 32-005 7272 ☐ 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: Kim Lamon

Street Address (P O Box Number is Not Acceptable): 808 Bentwood Drive

Suite, Apt #, Etc:

City: Naples State: FL Zip Code: 34108

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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 X _____ REGISTERED AGENT MUST SIGN

Date X 2/28/13

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
P	David Lamon	808 Bentwood Drive	Naples, FL 34108

10. E-mail Address: kimlamon@hotmail.com

(To be used for future annual report notification)

MAR - 4 2013

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 upon 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., and that all fees owed by the corporation have been paid. I further certify the information indicated on this application is true and accurate, and my signature shall have the same legal effect as if made under oath. I am aware that false information submitted in a document to the Department of State constitutes a third degree felony as provided for in s 817.155, F S

D BUTLER

SIGNATURE: X _____ m.d David J. Lamon, MD X 2/28/13 239-514-0934

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #