

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

**CORPORATION
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

FILED

09 JUL 22 PM 12:50

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P04000005789

1. Corporation Name

JAX'S FAMILY CARE & RESEARCH CENTER PA.

2. Principal Office Address - No P.O. Box #

5233 RICKER ROAD

3. Mailing Office Address

5233 RICKER ROAD

Suite, Apt. #, etc.

SUITE 101

Suite, Apt. #, etc.

SUITE 101

City & State

JACKSONVILLE, FL

City & State

JACKSONVILLE, FL

Zip

32210

Country

US

Zip

32210

Country

US

4. Date Incorporated or Qualified
To Do Business in Florida

12/23/2003

5. FEI Number
75-3148738

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

JAIR DE LA HOZ, MD

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

5233 RICKER ROAD

Suite, Apt. #, Etc.

SUITE 101

City

JACKSONVILLE

State

FL

Zip Code

32210

☐ The reinstatement fee is imposed, except in circumstances which the entity did not receive the prior notices. By checking this box, you are certifying the prior notices were not received and requesting the reinstatement fee be waived.

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

J. De La Hoz

REGISTERED AGENT MUST SIGN

Date

7/16/09

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
PSTD	JAIR DE LA HOZ, MD	5233 RICKER RD #101	JACKSONVILLE, FL 32210

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:

J. De La Hoz

JAIR DE LA HOZ, MD

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

7/16/09

Date

904-674-0151

Daytime Phone #