



2007 FOR PROFIT CORPORATION REINSTATEMENT

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|--|---|--|--|---|--|---|--|
| DOCUMENT # P05000069478 1. Entity Name DAVID TORRES M.D. P.A. | | | |  | | FILED 07 OCT 23 AM 10:41 DEPT. OF STATE TALLAHASSEE, FLORIDA | |
| Principal Place of Business 2215 NEBRASKA AVE 1C FORT PIERCE, FL 34950 | | | | Mailing Address 2215 NEBRASKA AVE 1C FORT PIERCE, FL 34950 | | | |
| 2. Principal Place of Business - No P.O. Box # Suite, Apt. #, etc. City & State Zip Country | | | | 3. Mailing Address Suite, Apt. #, etc. City & State Zip Country | | | |
| REINSTATEMENT | | | |  10052007 REIN-1 CB2E098 (1/07) | | | |
| 4. FEI Number 20-2984003 | | | | Applied For <input type="checkbox"/> Not Applicable | | | |
| 5. Certificate of Status Desired <input type="checkbox"/> | | | | \$8.75 Additional Fee Required | | | |
| 6. Name and Address of Current Registered Agent TORRES, DAVID 7691 CHARLESTON WAY PORT ST. LUCIE, FL 34986 | | | | 7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) City FL Zip Code | | | |
| 8. The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. I am familiar with, and accept the obligations of registered agent. | | | | | | | |
| SIGNATURE _____ <small>Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE</small> | | | | | | | |
| FILE NOW!!! FEE IS \$750.00 After January 1, 2008, Fee will be \$900.00 | | | | | | | |
| 10. OFFICERS AND DIRECTORS | | | | 11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11 | | | |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | P TORRES, DAVID 7691 CHARLESTON WAY PORT ST. LUCIE, FL 34986 | | | <input type="checkbox"/> Delete | TITLE NAME STREET ADDRESS CITY-ST-ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition | |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | [Blank] | | | <input type="checkbox"/> Delete | TITLE NAME STREET ADDRESS CITY-ST-ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition | |
| TITLE NAME STREET ADDRESS CITY-ST-ZIP | [Blank] | | | <input type="checkbox"/> Delete | TITLE NAME STREET ADDRESS CITY-ST-ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition | |
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| TITLE NAME STREET ADDRESS CITY-ST-ZIP | [Blank] | | | <input type="checkbox"/> Delete | TITLE NAME STREET ADDRESS CITY-ST-ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition | |
| 12. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Chapter 119, Florida Statutes. I further certify that the information indicated on this report or supplemental report is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am an officer or director of the corporation or the receiver or trustee empowered to execute this report as required by Chapter 607, Florida Statutes; and that my name appears in Block 10 or Block 11 if changed, or on an attachment with an address, with all other like empowered. | | | | | | | |
| SIGNATURE _____ DAVID TORRES MD DAVID TORRES <small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR</small> | | | | | | | |
| Date: 10/18/07 Daytime Phone #: 712-489-9697 | | | | | | | |