

# **2014 FOR PROFIT CORPORATION REINSTATEMENT**

DOCUMENT# P07000059797

**FILED**  
**Feb 01, 2014**  
**Secretary of State**

**Entity Name:** ST. ANTHONY'S FAMILY MEDICAL PRACTICE, M.D., P.A.

**Current Principal Place of Business:**

1584 CITRUS MEDICAL CT  
OCOE, FL 34761

**New Principal Place of Business:**

**Current Mailing Address:**

1584 CITRUS MEDICAL CT  
OCOE, FL 34761

**New Mailing Address:**

**FEI Number:** 26-0231679

**FEI Number Applied For ( )**

**FEI Number Not Applicable ( )**

**Certificate of Status Desired ( )**

**Name and Address of Current Registered Agent:**

ALATRISTE, ANTHONY  
8366 TIBET BUTLER DRIVE  
WINDERMERE, FL 34786 US

**Name and Address of New Registered Agent:**

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.

**SIGNATURE:** ANTHONY ALATRISTE

Electronic Signature of Registered Agent

Date

**OFFICERS AND DIRECTORS:**

**Title:** P  
**Name:** ALATRISTE, ANTHONY  
**Address:** 8366 TIBET BUTLER DR  
**City-St-Zip:** WINDERMERE, FL 34786

**Title:** VP  
**Name:** JIMENEZ, MILDRED  
**Address:** 8366 TIBET BUTLER DR  
**City-St-Zip:** WINDERMERE, FL 34786

**Title:** S  
**Name:** ALATRISTE, JONATHAN  
**Address:** 8366 TIBET BUTLER DR  
**City-St-Zip:** WINDERMERE, FL 34786

I hereby certify that the information indicated on this report or supplemental report is true and accurate and that my electronic 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 above, or on an attachment with all other like empowered.

**SIGNATURE:** ANTHONY ALATRISTE

DR

02/01/2014

Electronic Signature of Signing Officer or Director

Date