

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

**CORPORATION  
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE  
Secretary of State  
DIVISION OF CORPORATIONS

**DOCUMENT # P07000084084**

1. Corporation Name

**RECOVERY CENTERS OF AMERICA, INC.**

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

**111 Medical Center Avenue**

Suite, Apt. #, etc.

City & State

**Sebring, Florida**

Zip

**33870**

Country

**USA**

3. Mailing Office Address

**111 Medical Center Avenue**

Suite, Apt. #, etc.

City & State

**Sebring, Florida**

Zip

**33870**

Country

**USA**

4. Date Incorporated or Qualified  
To Do Business in Florida

**7/25/2007**

5. FEI Number

**260602197**

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

**Michael Hartman**

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

**111 Medical Center Avenue**

Suite, Apt. #, Etc.

City

**Sebring**

State

**FL**

Zip Code

**33870**

☒ 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

*Michael Hartman, Corp*

Date **12/31/2009**

REGISTERED AGENT MUST SIGN

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	Michael Hartman	111 Medical Center Avenue	Sebring, FL 33870

**REINSTATEMENT**

**RH**

10. E-mail Address: **Counselorman1@embarqmail.com**

(To be used for future annual report notification)

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 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. 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.

**SIGNATURE:**

*Michael Hartman, CCSC*

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

**12/31/2009 863 402 9106**

Date

Daytime Phone #

**FILED**

**10 JAN -7 AM 9:39**

**SECRETARY OF STATE  
TALLAHASSEE, FLORIDA**

**700165130077**  
**01/07/10--01037--005 \*\*150.00**

CR2E081 (11/09)