PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

FILED
SECRETARY OF STATE
DIVISION OF CORPORATIONS

2020 SEP -3 PM 12:07

CORPORATION REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # P12000013712

1. Corporation Name

SPACE COAST NEUROSURGERY, PA

900351515,19
09/04/20--01002--022 **700.00

CR2E081 (11/10)

2. Principal Office Address - No P.O. Box #	3. Mailing Office Address
2263 W. NEW HAVEN AVE, #108	
Suite, Apt. #, etc	Suite, Apt. #, etc.
City & State	City & State
W. MELBOURNE, FL	W. MELBOURNE, FL
Zip / Country	Zip / Country
32904 / USA	32904 / USA

4. Date Incorporated or Qualified To Do Business in Florida: 2012

5. FEI Number: 45-4492110 ☐ 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: BENNETT S. COHN, ESQ.

Street Address (P.O. Box Number is Not Acceptable): 1229-B NORTH DIXIE HWY

Suite, Apt. #, etc:

City: LAKE WORTH BEACH | State: FL | Zip Code: 33460

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: Bennett S. Cohn Date: 8-31-20

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
PRES.	AARON M SMITH	384-1 PRESTWICK CIR.	PALM BEACH GARDENS, FL 33418

REINSTATEMENT

SEP 03 2020
C.T.
R. HUNT

10. E-mail Address: spacecoastneurosurgery@yahoo.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., 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.

SIGNATURE: AARON M. SMITH 8/31/20 321-890-2284

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