

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION
FOR
REINSTATEMENT



FLORIDA DEPARTMENT OF STATE
Katherine Harris
Secretary of State
DIVISION OF CORPORATIONS

FILED
SECRETARY OF STATE
TALLAHASSEE, FLORIDA
01 OCT 25 PM 3:03

DOCUMENT # **P21427**

1. Corporation Name

CORRECTIONAL MEDICAL SERVICES, INC.

Principal Place of Business

Mailing Address

12647 OLIVE ST.
ST. LOUIS MO 63141-6345

12647 OLIVE ST.
ST. LOUIS MO 63141-6345

If above addresses are incorrect in any way, line through incorrect information and enter correction below.

2. New Principal Office Address, If Applicable

3. New Mailing Office Address, If Applicable

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

Zip

Country

Zip

Country

4. Date Incorporated or Qualified
To Do Business in Florida

10/24/1988

SP

5. FEI Number

43-1281312

Applied For

Not Applicable

6.

CERTIFICATE OF STATUS DESIRED ☐

\$8.75 Additional Fee required
for a Certificate of Status

7. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at least 3 directors)

Title(s) 1	Name of Officers and/or Directors 2	Street Address of Each Officer and/or Director 3	City / State / Zip 4
PD	MILES, RICHARD H	12647 OLIVE BLVD.	ST LOUIS MO 63141
EVD	MOORE, JAMES	12647 OLIVE BLVD.	ST LOUIS MO 63141
S	KIM, RUTH E	12647 OLIVE BLVD	ST LOUIS MO 63141
T	MAHONEY, MELVIN	12647 OLIVE BLVD.	ST LOUIS MO 63141
V	VIVIRITO, CATHY	12647 OLIVE STREET	ST LOUIS MO 63141
VD	POWERS, SALLY A	12647 OLIVE STREET	SAINT LOUIS MO 63141

8. Name and Address of Current Registered Agent

CT CORPORATION SYSTEM
1200 S. PINE ISLAND ROAD
PLANTATION FL 33324

9. Name and Address of New Registered Agent

Name

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

800004658278--1

Suite, Apt. #, Etc.

10/30/01 01006 014

****750.00 ****750.00

City

State

FL

Zip Code

10. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of Section 607.0505, F.S.

Signature of
Registered Agent

Barbara A. Burke

BARBARA A. BURKE
SPECIAL ASSISTANT SECRETARY

Date

10/18/01

REGISTERED AGENT MUST SIGN

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 and the names of individuals listed on this form do not qualify for an exemption under section 119.07(3)(l), 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:

MELVIN M. MAHONEY
MELVIN M. MAHONEY

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

10/17/01

Daytime Phone #

CR2040 (8-01)