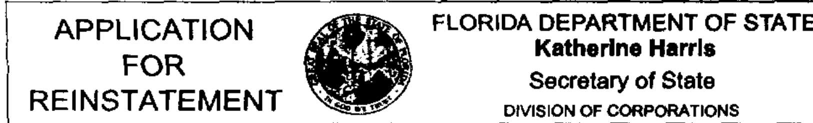
PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.



APPLICATION FOR REINSTATEMENT

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

FILED
99 NOV -4 PM 4:21
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P93000040261

1. Corporation Name

ROBERT KOE, M.D., P.A.

Principal Place of Business	Mailing Address
1543 KINGSLEY AVE. # 12 ORANGE PARK FL 32073	1543 KINGSLEY AVE. # 12 ORANGE PARK FL 32073

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: 06/08/1993

5. FEI Number: 58-2062096 ☐ 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
D	KOE, ROBERT	1543 KINGSLEY AVE., BUILDING 12	ORANGE PARK FL 32073
			200003046362--2 -11/16/99--01097--015 ****150.00 ****150.00
		T8	

8. Name and Address of Current Registered Agent	9. Name and Address of New Registered Agent
KOE, ROBERT M.D. 1543 KINGSLEY AVE. # 12 ORANGE PARK FL 32073	Name Street Address (P.O. Box Number is Not Acceptable) Suite, Apt. #, Etc. 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 [signature] REGISTERED AGENT MUST SIGN Date 10/23/99

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)(i), 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: [signature] ROBERT KOE, M.D., P.A. 10/23/99 904-269-9777
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CR2E040 (8/99)

ROBERT KOE, M.D., P.A.

DIPLOMATE OF AMERICAN BOARD OF INTERNAL MEDICINE

KINGSLEY VILLAGE MEDICAL CENTER
1543 Kingsley Ave. Bldg. 12 Orange Park, FL 32073

Tel. No. (904) 269-9777
(904) 264-9774

October 22, 1999

Division Of Corporations
Annual Report/Reinstatement Section
PO Box 6327
Tallahassee, FL 32314-6327

TO WHOM IT MAY CONCERN:

As discussed over the phone with your department, I would like to request a one time waiver for the reason that perhaps because of postal inconsistency, I have not received the first notice for filing the corporation tax. As you have instructed, I am sending the original amount fee of $150.00 and the current form filled out.

Thank you for your kind consideration.

Sincerely,

Robert Koe, M.D., P.A.