(1)

APPROVED
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PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

1997 APR 30 AM 9:42

FAX AUDIT#: H97000007031

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

APPLICATION FOR REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Sandra B. Mortham
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # P94000033378

1. Corporation Name
ELOISE NURSING HOME, INC.

Principal Place of Business	Mailing Address
2035 NW 191ST TERRACE MIAMI FL 33056	2035 NW 191ST TERRACE MIAMI FL 33056

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: 05/05/1994

5. FEI Number: 65-0485705 ☐ Applied For ☐ Not Applicable

6. CERTIFICATE OF STATUS DESIRED ☐ [redacted]

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 (Do NOT Use Post Office Box Numbers) 3	City / State / Zip 4
D	FLOCKER, MARION S	2045 NW 191ST TERRACE	MIAMI FL 33056

REINSTATEMENT '96-'97

SCC 4-30-97

8. Name and Address of Current Registered Agent

BERNARD, ANTHONY
16201 SW 95TH AVENUE
STE. 109
MIAMI FL 33157

9. Name and Address of New Registered Agent

Name

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

Suite, Apt. #, Rm

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] Date: 4/27/97

REGISTERED AGENT MUST SIGN

11. Does this corporation pay any intangible tax to the Dept. of Revenue under S. 199.032, Florida Statutes. Yes ☒ No ☐ (See other side for information on intangible tax.)

12. 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.

Marion Flocker

SIGNATURE: SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

4/27/97 Date

305-217443 Daytime Phone #

FAX AUDIT#: H97000007031

P94000033378 (2)

4/29/97 FLORIDA DIVISION OF CORPORATIONS 3:43
PUBLIC ACCESS SYSTEM
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(((H97000007031 2)))

TO: DIVISION OF CORPORATIONS FAX #: (904)922-4000

FROM: ANTHONY P. BERNARD ACCT#: 071162000147
CONTACT: ANTHONY BERNARD
PHONE: (305)251-4591 FAX #: (305)251-1975

NAME: ELOISE NURSING HOME, INC.
AUDIT NUMBER.....H97000007031
DOC TYPE.....CORPORATION REINSTATEMENT
CERT. OF STATUS..0 PAGES..... 1
CERT. COPIES.....0 DEL.METHOD.. FAX
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