

H05000120036 3

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

FILED

05 MAY 11 PM 4:42

SECRETARY OF STATE
TALLAHASSEE, FLORIDACORPORATION
REINSTATEMENTFLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # P95000003033

1. Corporation Name

WOUND CARE ASSOCIATES, INC.

2. Principal Office Address

7263 Captain Kidd Reef

3. Mailing Office Address

same

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

Pensacola, FL

City & State

Zip

32507

Country

US

Zip

Country

4. Date Incorporated or Qualified
To Do Business in Florida

1/9/95

5. FEI Number

593291505

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

Alison Davenport

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

7263 Captain Kidd Reef

Suite, Apt. #, Etc.

City

Pensacola

State

FL

Zip Code

32507

8. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of section 807.0505 or 617.0503, F.S.

Signature of
Registered Agent*Alison P. Davenport*

Date

5/11/05

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/D	Davenport, Alison	7263 Captain Kidd Reef	Pensacola, FL 32507

10. 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)(b), 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.

Alison Davenport, President

SIGNATURE:

Alison P. Davenport

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

5/11/05 (850) 492-7659

Date

Daytime Phone #

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Florida Department of State
Division of Corporations
Public Access System

Electronic Filing Cover Sheet

Note: Please print this page and use it as a cover sheet. Type the fax audit number (shown below) on the top and bottom of all pages of the document.

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To:

Division of Corporations
Fax Number : (850) 205-0384

From:

Account Name : CLARK, PARTINGTON, HART AND HART
Account Number : 071201002016
Phone : (850) 434-9200
Fax Number : (850) 432-7340

CORPORATION REINSTATEMENT

WOUND CARE ASSOCIATES, INC.

Certificate of Status	0
Certified Copy	0
Page Count	01
Estimated Charge	\$1,050.00

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APPLICATION FOR REGISTRATION OF FICTITIOUS NAME

Note: Acknowledgements/certificates will be sent to the address in Section 1 only.

FILED

05 MAY 11 PM 4:21

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

Section 1

1. FiCore Funding, Inc.
Fictitious Name to be Registered (see instructions if name includes "Corp" or "Inc")
16875 W. Bernardo Drive
Suite 100
Mailing Address of Business
San Diego CA 92127
City State Zip Code

3. Florida County of principal place of business: _____

All Multi
(see instructions if more than one county)

This space for office use only

Section 2

A. Owner(s) of Fictitious Name If Individual(s): (Use an attachment if necessary):

1. Last _____ First _____ M.I. _____ Address _____ City _____ State _____ Zip Code _____	2. Last _____ First _____ M.I. _____ Address _____ City _____ State _____ Zip Code _____
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B. Owner(s) of Fictitious Name If other than an Individual: (Use attachment if necessary):

1. <u>FiCore Mortgage, Inc.</u> Entity Name <u>16875 W. Bernardo Drive, Suite 100</u> Address <u>San Diego</u> <u>CA</u> <u>92127</u> City State Zip Code Florida Registration Number <u>E0500002145</u> FEI Number: <u>33-0694-856</u> <input checked="" type="checkbox"/> Applied for <input type="checkbox"/> Not Applicable	2. _____ Entity Name Address _____ City _____ State _____ Zip Code _____ Florida Registration Number _____ FEI Number: _____ <input type="checkbox"/> Applied for <input type="checkbox"/> Not Applicable
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Section 3

I (we) the undersigned, being the sole (all the) party(ies) owning interest in the above fictitious name, certify that the information indicated on this form is true and accurate. In accordance with Section 865.09, F.S., I (we) understand that the signature(s) below shall have the same legal effect as if made under oath. (At Least One Signature Required)

<u>[Signature]</u> Signature of Owner Date <u>4-7-05</u> Phone Number: <u>(858) 753-1245</u>	_____ Signature of Owner Date _____ Phone Number: _____
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Section 4

FOR CANCELLATION COMPLETE SECTION 4 ONLY: FOR FICTITIOUS NAME OR OWNERSHIP CHANGE COMPLETE SECTIONS 1 THROUGH 4:

I (we) the undersigned, hereby cancel the fictitious name _____
_____, which was registered on _____ and was assigned
registration number _____

G05131900027
05/12/05--01001--016 **50.00

_____ Signature of Owner	_____ Date	_____ Signature of Owner	_____ Date
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Mark the applicable boxes ☐ Certificate of Status — \$10 ☐ Certified Copy — \$30

NON-REFUNDABLE PROCESSING FEE: \$50