

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

**CORPORATION  
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE  
Secretary of State  
DIVISION OF CORPORATIONS

FILED

03 SEP 10 PM 1:31

SECRETARY OF STATE  
TALLAHASSEE FLORIDA

DOCUMENT # 995000007738

1. Corporation Name

Lakemont Clinic INC.

2. Principal Office Address

1870 Aloma Avenue

Suite, Apt. #, etc.

110

City & State

Winter Park

Zip

32789

Country

USA

3. Mailing Office Address

1870 Aloma Avenue

Suite, Apt. #, etc.

# 110

City & State

Winter Park

Zip

32789

Country

USA

4. Date Incorporated or Qualified  
To Do Business in Florida

01/25/1995

5. FEI Number

59-3278541

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

Tim Fennell

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

1870 Aloma Ave #110

Suite, Apt. #, Etc.

110

City

Winter Park

State  
FL

Zip Code

32789

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

Tim Fennell

REGISTERED AGENT MUST SIGN

Date

9-9-03

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	Fennell Timothy	1870 Aloma Ave #110	Winter Park 32789

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)(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: Tim Fennell

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

9-9-03

Daytime Phone #

407 629-2883

CR2E081 (10/02)

9/10

LAKEMONT CLINIC INC.  
1870 ALOMA AVENUE SUITE 110  
WINTER PARK FLORIDA 32792  
407-629-2883

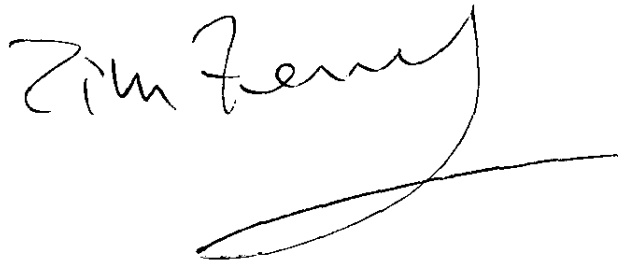
09/09/03

I am writing to request waiver of \$600 reinstatement fee due to not receiving dissolution notice. After speaking to Ruby from your office they had the wrong mailing typo error for registered agent on LAKEMONT CLINIC INC.

FEI Number 593278541

Thank you

Tim Fennell President

A handwritten signature in black ink, appearing to read "Tim Fennell", with a long, sweeping horizontal stroke extending to the right.