PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

CORPORATION REINSTATEMENT					FLO	FLORIDA DEPARTMENT OF STATE Secretary of State DIVISION OF CORPORATIONS						VISION OF CORPORATION O4 MAY 27 AM 11: 10							
DOCUMENT # P95000051504 1. Corporation Name DR. DALE WICKSTROM-HILL, P.A.																·· / ()			
WINTER HAVEN HOSPITAL P.O. BOX 9499											05	80 727,	1 00 104	37 0101	36 50(16: 12:	4 ⊟ **18	08.75	
2. Principal Office Address WINTER HAVEN HOSPITAL				_ I	3. Mailing Office Address P.O. BOX 9499					R	EIN	S	AI	ren		VT	97-	04	
Suite, Apt. #, etc.				Suit	Suite, Apt. #, etc.					4. Date	incorp	orated or	Qualific	ed 5/29/19	íne.				
City & State WINTER HAVEN, FL				1 *	City & State WINTER HAVEN, FL					5. FEI		·	01102 6)/29/18	95	\vdash	pplied Fo	_	
zip 33881	Country USA			Zip 33	ZIP 33883			ry								ddition	al Fee rec ate of Sta	uired	
·	Name DR. DALE WICKSTROM-HILL Street Address (P.O. Box Number is Not Acceptable) 200 AVE F, NE Suite, Apt. #, Etc.																		
	City WINTER	R HAV	ΈN									,	State FL	Zip 338	Code 881				
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 REGISTERED AGENT MUST SIGN												CR2E081 (01/04)							
	lames and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at Name of Street Address of Each											tors)							 .
Titles	Officers and/or Directors			rs	Officer and/or E					ector				City / State / Zip					
PRES	DR. DALE WICKSTROM-HIL				IILL	L _ 200 AVE F, NE					-:		WINT	ERH	HAVEN	N, EL :	3388	1	
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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 filling 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:													s ted						
i	Si	GNATUR	E AND T	YPED OR I	PRINTED	NAME OF	SIGNING O	FFICER O	R DIRECTOR	ı			Date	į		Daytime	Phone i	r	1