

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION
FOR
REINSTATEMENT



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

DOCUMENT # **P95000052599**

1. Corporation Name

NATIONS HEALTH PROFESSIONAL SERVICES, INC. *9602*

Principal Place of Business

Mailing Address

8276 NW S. RIVER DRIVE
MEDLEY FL 33166
US

8276 NW S. RIVER DRIVE
MEDLEY FL 33166
US

If these 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

07/03/1995

5. FEI Number

65-0593675

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)	Name of Officers and/or Directors	Street Address of Each Officer and/or Director	City / State / Zip
1	2	3	4
PSD	ESPARZA, ANA	8276 NW S. RIVER DRIVE	MEDLEY FL 33166
VTD	PEREZ, ARELYS	8276 NW S. RIVER DRIVE	MEDLEY FL 33166

200003051472--1
-11/22/99--01117--006
****150.00 ****150.00

TS

8. Name and Address of Current Registered Agent

9. Name and Address of New Registered Agent

ESPARZA, ANA
8276 NW S. RIVER DRIVE
MEDLEY FL 33166-7420

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

REGISTERED AGENT MUST SIGN

Date

10/18/99

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 AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

10/18/99

Daytime Phone #

FILED

99 NOV -8 AM 11:10

SECRETARY OF STATE
TALLAHASSEE, FLORIDA



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CR2040 (8/99)

Nations Health Professional Services, Inc.
A Home Health Agency
8276 So River Drive Medley Florida, 33176
Tel. 305-882-0603 / Fax 305-882-0681

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To: Florida Department of State
Division of Corporation

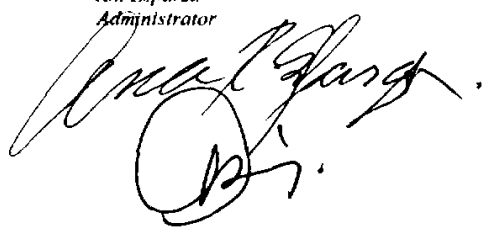
Please be advised that at no given time before this date Nations Health Professional was sent any documentation in regards to the Division of Corporation. It was not until today 10-99 that anything was sent to our attention regarding the Application or reinstatement of the corporation No. P95000052599.

Therefore at this time I would like to see if Nations Health Professional is granted a One time waiver reinstatement. I am sure this will not ever occurs since now we know of such commitment.

Our deepest apologies for this inconvenience, at this time this said request for the first time waiver is highly appreciated

Thank You

Ani Esparza
Administrator

A handwritten signature in black ink, appearing to read 'Ani Esparza', with a large circular flourish underneath.