

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION
FOR
REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Jim Smith
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # **P95000095963**

1. Corporation Name

BROWARD COUNTY DENTAL SURGERY, P.A.

Principal Place of Business

5181 N.E. 19TH AVENUE
FT. LAUDERDALE FL 33308

Mailing Address

5181 N.E. 19TH AVENUE
FT. LAUDERDALE FL 33308

If above addresses are incorrect in any way, line through incorrect information and enter correction below.

2. New Principal Office Address, If Applicable

Suite, Apt. #, etc.

City & State

Zip

Country

3. New Mailing Office Address, If Applicable

Suite, Apt. #, etc.

City & State

Zip

Country

4. Date Incorporated or Qualified
To Do Business in Florida

12/19/1995

5. FEI Number

65-0632683

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
PST	CLARKE, JOHN R	5181 N.E. 19TH AVENUE	FT. LAUDERDALE FL 33308

8. Name and Address of Current Registered Agent

CLARKE, JOHN R
5181 N.E. 19TH AVENUE
FT. LAUDERDALE FL 33308

9. Name and Address of New Registered Agent

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. or 617.0505, F.S.

Signature of
Registered Agent

REGISTERED AGENT MUST SIGN

Date

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

Daytime Phone #

FILED

02 DEC 05 PM 12:27

SECRET
TALL... STATE

200009739982
12/30/02--01036--014 **150.00



CR2E040 (8/02)

BROWARD COUNTY DENTAL SURGERY, P.A.

PO BOX 11223

FORT LAUDERDALE, FLORIDA 33339-1223

December 26, 2002

Department of State
Division of Corporations
PO Box 6327
Tallahassee, FL 32314

Re: Application for Reinstatement

To Whom It May Concern:

Please be advised that for whatever reason, we have not received the previous UBR notices that were or were not mailed to the above business address. Please accept the enclosed filing and payment in the amount of \$150.00 for reinstatement.

Sincerely,



Michael J. Lennon
Accountant
