

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION  
FOR  
REINSTATEMENT



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

DOCUMENT # **P96000065045**

1. Corporation Name

**LOVING ADULT FAMILY CARE CORP.**

99AL

Principal Place of Business

15330 OCEAN BREEZE LN  
WELLINGTON FL 33414  
US

Mailing Address

15330 OCEAN BREEZE LANE  
WELLINGTON FL 33414  
US

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

08/02/1996

5. FEI Number

65-0691830

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)

1 Title(s)	2 Name of Officers and/or Directors	3 Street Address of Each Officer and/or Director	4 City / State / Zip
D	HOLLOWAY, IRENE	15330 OCEAN BREEZE LANE	WELLINGTON FL 33414

000003035900--4  
-11/05/99--01013--017  
\*\*\*150.00 \*\*\*150.00

TS

8. Name and Address of Current Registered Agent

9. Name and Address of New Registered Agent

HOLLOWAY, IRENE  
15330 OCEAN BREEZE LN  
WELLINGTON FL 33414

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

*Irene Holloway*  
REGISTERED AGENT MUST SIGN

Date 10-13-99

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:

*Irene Holloway*  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

10-13-99

FILED

99 OCT 28 PM 4:40

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA



CR20040 (8/99)

October 10, 1999

Division of Corporations: 2

Loring Adult Family Care Corp, received  
of letters on yesterday state my Corporation  
was revoked September 24, 1999

Please, note on July 3 this year Loring  
Adult Family mailed a money order  
to the Division of Corporations in the amount  
of \$150<sup>00</sup> which the Division of Corporations  
say they did not receive.

Today Loring Adult Family Care Corp  
is sending another \$150<sup>00</sup> money order  
to Reinstate my Corporation.

I will send my \$150<sup>00</sup> to address

Division of Corporations  
P.O. Box 6327

Tallahassee, Florida 32314

Thankyou Gene Holloway