

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

FILED

03 APR 16 PM 1:40

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

CORPORATION
REINSTATEMENT



FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # P96000081028

1. Corporation Name

ORLANDO PRIMARY CARE, P.A.

2. Principal Office Address

1511 B Sligh Blvd.

Suite, Apt. #, etc.

3. Mailing Office Address

1511 B Sligh Blvd.

Suite, Apt. #, etc.

City & State

Orlando, Florida

City & State

Orlando, Florida

Zip

32806

Country

USA

Zip

32806

Country

USA

4. Date Incorporated or Qualified
To Do Business in Florida

9/30/86

5. FEI Number

59-3402210

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

JAMES J. HOCTOR

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

215 North Eola Drive

Suite, Apt. #, Etc.

City

Orlando,

State
FL

Zip Code

32801

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

James J. Hoctor
JAMES J. HOCTOR

REGISTERED AGENT MUST SIGN

Date

4/15/03

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
D	ZIAJKA, PAUL E. M.D.	1511 B Sligh Boulevard	Orlando, Florida 32806

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:

Paul Zajka

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR
PAUL E. ZIAJKA, M.D., DIRECTOR

4/14/03

Date

407-849-0484

Daytime Phone #

CR2ED081 (10/02)