

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION
FOR
REINSTATEMENT



FLORIDA DEPARTMENT OF STATE
Glenda E. Hood
Secretary of State
DIVISION OF CORPORATIONS

FILED

03 OCT 21 AM 10:35

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P96000092272

1. Corporation Name

DELTA HEALTH MANAGEMENT INC.

Principal Place of Business

Mailing Address

1 DOCTORS LANE
LAKE WALES FL 33853

1 DOCTORS LANE
LAKE WALES FL 33853

If above 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

11/12/1996

5. FEI Number

59-3398671

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) 1	Name of Officers and/or Directors 2	Street Address of Each Officer and/or Director 3	City / State / Zip 4
P	WEAVER, M M	1 DOCTORS LANE	LAKE WALES FL 33853

200023967432
10/21/03--01052--008 **150.00

8. Name and Address of Current Registered Agent

9. Name and Address of New Registered Agent

WEAVER, M. MAX
1 DOCTORS LANE
LAKE WALES FL 33853

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

10-16-03

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 #

10-16-03

CR2E040 (7/03)

M. Max Weaver D.D.S.



PHONE (863) 676-8536

ONE DOCTORS LANE

LAKE WALES, FLORIDA 33853

October 16, 2003


Florida Department of State
Annual Report/Reinstatement Section
PO Box 6327
Tallahassee, Florida 32314-6327

Re: Document # P96000092272

Dear Sirs:

Please return our dissolved/revoked corporation to active status with the enclosed filing fee of One Hundred Fifty Dollars (\$150.00). To my knowledge our office did not received the two prior business report (UBR) notices.

Thank you for your cooperation in this matter.


M. Max Weaver, D.D.S.