

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

**CORPORATION
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # **P97000034899**

1. Corporation Name

GOLD COAST MEDICAL CENTERS, INC.

2. Principal Office Address

950 SE 5TH AVE

Suite, Apt. #, etc.

City & State

DELRAY BEACH, FL

Zip

33483

Country

U.S.A

3. Mailing Office Address

950 SE 5TH AVE

Suite, Apt. #, etc.

City & State

DELRAY BEACH, FL

Zip

33483

Country

U.S.A

FILED

06 SEP 22 PM 2:28

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

CR2E081 (12/05)

4. Date Incorporated or Qualified
To Do Business in Florida

4/18/1997

5. FEI Number

650802985

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

KOITA MUNIRA M

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

950 SE 5TH AVE

Suite, Apt. #, Etc.

City

DELRAY BEACH, FL

State

FL

Zip Code

33483

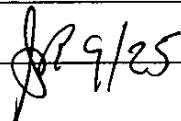
8. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of section 607.0505 or 617.0503, F.S.

Signature of
Registered Agent

Date

REGISTERED AGENT MUST SIGN

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	KOITA MUNIRA M	950 SE 5TH AVE	DELRAY BEACH, FL 33483
			300080221103 09/27/08--01048--004 **1050.00

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 contained in Chapter 119, 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

9/19/2006

Date

561-809-9700

Daytime Phone #