

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 NOV 20 PM 2:20

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # **P97000080121**

1. Corporation Name

CENTRAL FLORIDA PHYSICIANS NETWORK, INC.

Principal Place of Business

Mailing Address

500 EAST CENTRAL AVENUE
WINTER HAVEN FL 33880

500 EAST CENTRAL AVENUE
WINTER HAVEN FL 33880



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

09/15/1997

5. FEI Number

59-3515394

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 |
|---------------|---|--|--|
| D | CARIFI, VINCENT G MD | 500 EAST CENTRAL AVENUE | WINTER HAVEN FL 33880 |
| D | BERGNES, JOSEPH A M.D. | 635 1ST STREET NORTH | WINTER HAVEN FL 33880 |
| D | INMAN, CHARLES C MD | 500 EAST CENTRAL AVENUE | WINTER HAVEN FL 33880 |
| D | MCGETRICK, JOHN J MD | 635 FIRST ST. NORTH | WINTER HAVEN FL 33880 |
| | | | 11/20/03--01082--001 **150.00 100024894731 11/20/03--01082--001 **150.00 |

8. Name and Address of Current Registered Agent

9. Name and Address of New Registered Agent

CARIFI, VINCENT G MD
500 EAST CENTRAL AVENUE
WINTER HAVEN FL 33880

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

Date

11-19-03

REGISTERED AGENT MUST SIGN

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

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

11-19-03

CR2E040 (7/03)



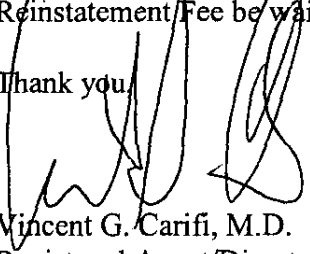
November 19, 2003

Department of State
Division of Corporations
P.O. Box 6327
Tallahassee, FL 32314

To Whom It May Concern:

Central Florida Physician's Network, Inc. (Document Number P97000080121), is writing this letter to notify the Department of State that we did not receive our two Uniform Business Report notifications for 2003. Therefore, we are requesting that the Corporate Reinstatement Fee be waived for this Corporation.

Thank you,


Vincent G. Carifi, M.D.
Registered Agent/Director
Central Florida Physician's Network, Inc.