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.

REINSTATEMENT 03

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

CR2E040 (7/03)

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 SIGNATURE 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 11-19-03

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

BOND CLINIC
PROFESSIONAL•ASSOCIATION

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.

500 East Central Avenue • Winter Haven, Florida 33880-3094 • 863/293-1191 • Fax 863/293-6940
1342 S.R. 60 East • Lake Wales, Florida 33853 • 863/679-1552 • Fax 863/679-8653