PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM. Page 1 of 2

APPLICATION FOR [redacted]

FLORIDA DEPARTMENT OF STATE
**Katherine Harris**
Secretary of State
DIVISION OF CORPORATIONS

FILED
00 NOV -3 AM 10:25
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # **P97000090005**

1. Corporation Name

**ATLANTIC DENTURE CLINIC, P.A.**

| Principal Place of Business | Mailing Address |
|---|---|
| 904 SOUTH U.S. 1<br>ROCKLEDGE FL 32955 | 904 SOUTH U.S. 1<br>ROCKLEDGE FL 32955 |

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: **11/01/1997**

5. FEI Number: **59-3481292** ☐ 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 | HOLLOWAY, JAMES H JR. | 904 SOUTH U.S. 1 | ROCKLEDGE FL 32955 |
| | | | |
| | | | |
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| 8. Name and Address of Current Registered Agent | 9. Name and Address of New Registered Agent |
|---|---|
| HOLLOWAY, JAMES H JR.<br>904 SOUTH U.S. 1<br>ROCKLEDGE FL 32955 | Name<br>Street Address (P.O. Box Number is Not Acceptable)<br>Suite, Apt. #, Etc.<br>City / State: FL / Zip Code |

CR2E040 (8/00)

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.

Signature of Registered Agent: [signature] Date: 10/18/00
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] 10/18/00
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

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# ATLANTIC DENTURE CLINIC

James H. Holloway, D.M.D.

10/18/00

DEAR SIRS -

I SPOKE TO YOUR OFFICE AND CHECKED MY RECORDS. THE CHECK WE MAILED WITH OUR ORIGINAL FORM HAS NOT BEEN CASHED. YOUR OFFICE SAID TO SEND IN ORIGINAL FEE WITH THE CORPORATE PAPERS AS WE HAVE HAD A PAPERWORK PROBLEM. THANK YOU FOR YOUR ASSISTANCE

904 South US1 • Old Searstown Plaza • Rockledge, Florida 32955 • (407) 631-3155