

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION
FOR
REINSTATEMENT



FLORIDA DEPARTMENT OF STATE

Jim Smith

Secretary of State
DIVISION OF CORPORATIONS

FILED

02 OCT 28 AM 8:40

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P97000108256

1. Corporation Name

WEST BROWARD ORTHOPAEDICS & SPINE, P.A.

Principal Place of Business

Mailing Address

1855 N. CORPORATE LAKES BLVD.
WESTON FL 33326

1855 N. CORPORATE LAKES BLVD.
WESTON FL 33326

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

4. Date Incorporated or Qualified
To Do Business in Florida

12/24/1997

Suite, Apt. #, etc.

Suite, Apt. #, etc.

5. FEI Number

65-0801622

Applied For

Not Applicable

City & State

City & State

Zip

Country

Zip

Country

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	SCHECHTER, NEIL S	2744 OAKBROOK DR	WESTON FL 33332

000008638290
10/28/02--01133--010 **150.00

8. Name and Address of Current Registered Agent

9. Name and Address of New Registered Agent

SCHECHTER, NEIL A
2744 OAKBROOK DR.
WESTON FL 33332

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

Signature Required

REGISTERED AGENT MUST SIGN

Date

10/21/02

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 Required

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

10/21/02

Daytime Phone #

954-349-3416

CR2E040 (8/02)

WEST BROWARD ORTHOPAEDICS & SPINE

Neil A. Schechter, M.D.
Diplomate American Board of Orthopaedic Surgery

1855 N. Corporate Lakes Boulevard
Weston, FL 33326
Phone (954) 349-3416
Fax (954) 349-6993

October 21, 2002

Division of Corporations
Annual Report/Reinstatement Section
PO Box 6327
Tallahassee, FL 32314-6327

To Whom It May Concern:

Please note that I received the Notice of Administrative Dissolution or Revocation in the mail for the first time today. I did not receive any of the prior uniform business reports (UBR) notices. As you can confirm, I have always filed this report in a timely fashion in all previous years. Please find enclosed the \$150 fee for reinstatement of my corporation to active status. I appreciate your attention in this matter.

Sincerely,



Neil A. Schechter, M.D.
Owner/Director