

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION
FOR
REINSTATEMENT



FLORIDA DEPARTMENT OF STATE
Gathrin Harris
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # P98000004262

1. Corporation Name

COVENANT HEALTHCARE LAB, INC.

Principal Place of Business

Mailing Address

P.O. BOX 1779
SE CORNER OF BLOXHAM AND CLYDE STREETS
MAYO FL 32066

P.O. BOX 1779
SE CORNER OF BLOXHAM AND CLYDE STREETS
MAYO FL 32066

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

01/14/1998

5. FEI Number

59-3435318

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)

1. Title(s)	2. Name of Officers and/or Directors	3. Street Address of Each Officer and/or Director	4. City / State / Zip
OWNER	MARION H. COLLINS	PO BOX 1823 PERRY, FL. 32348	

000003035850--1
11/05/99-01011-024
****150.00 ****150.00

SP

8. Name and Address of Current Registered Agent

9. Name and Address of New Registered Agent

COLLINS, MARION H
SOUTHEAST CORNER OF BLOXHAM AND CLYDE ST.
MAYO FL 32066

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.

Signature of
Registered Agent

Marion H. Collins

Date

10/11/99

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:

Marion H. Collins

Date

10/11/99

Daytime Phone #

COVENANT HEALTHCARE LABS, INC.

904-294-4314

PO BOX 1779 MAYO, FLA. 32066

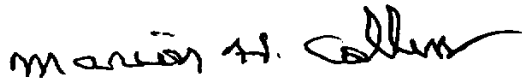
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OCTOBER 12, 1999

RE: REINSTATEMENT

TO WHOM IT MAY CONCERN, REGRETFULLY, WE DID NOT RECEIVE OUR RENEWAL APPLICATION EARLY THIS YEAR. WE WERE UNAWARE OF ANY FEES THAT MAY BE DUE ANNUALLY. THIS IS OUR SECOND YEAR AND HAVE NOW BEEN MADE AWARE OF ANNUAL CHARGES AND WILL BE CERTAIN TO PAY THEM IN A TIMELY MANNER.

SINCERELY,



MARION H. COLLINS, OWNER