

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION  
FOR  
REINSTATEMENT



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

FILED

99 DEC 13 PM 2:56

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

DOCUMENT #

1. Corporation Name

COASTAL MEDICAL ORTHOPEDIC SERVICES INC.

Principal Place of Business

Mailing Address

2828 SOUTH SEACREST BLVD  
SUITE 208  
BOYNTON BEACH FL 33435

SAME

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

2-24-98

5. FEI Number

65-083176-7

Applied For

Not Applicable

6. CERTIFICATE OF STATUS DESIRED ☐

SR 7: A 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)	Name of Officers and/or Directors	Street Address of Each Officer and/or Director (Do NOT Use Post Office Box Numbers)	City / State / Zip
P	WILLIAM FELD	7907 NW 62ND WAY	PARKLAND FL 33067
			600003077776--1 -12/22/99--01042--014 ***150.00 ***150.00

8. Name and Address of Current Registered Agent

9. Name and Address of New Registered Agent

WILLIAM FELD  
2828 SOUTH SEACREST BLVD  
SUITE 208  
BOYNTON BEACH FL 33435

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

*William Feld*

REGISTERED AGENT MUST SIGN

Date 12-9-99

11. This corporation owes the current year  
Intangible Personal Property Tax due June 30.

Yes ☐ No ☒

(See other side for information  
on intangible tax.)

12. 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 AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

*William Feld*

Date

Daytime Phone #

12-9-99 561733-5603

KE

CR2001 (12/98)

**CMS**

**Coastal Medical Orthopedic Services Inc.**

**2**

December 9, 1999

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

To Whom It May Concern:

Please find enclosed a check for \$150.00 for the filing fee for Coastal Medical Orthopedic Services Inc. I was instructed by your reinstatement department to pay this amount as we have not been receiving any correspondence from your office.

We have recently moved to: 2828 South Seacrest Blvd, Suite 208, Boynton Beach FL 33435, but we still receive mail at our previous address of: 102 Northeast Second Street, Suite 268, Boca Raton FL 33432. This year (1999) is the first year we are due for the corporation filing fee renewal. We did not receive anything from your office at either address and I believe the registered agent on file is incorrect as well.

If you have any questions or need further information, please call me at (561) 733-5603. I would appreciate any correspondence letting me know the status of this application.

Thank you for your prompt attention to this matter.

Sincerely,

  
Toni Falcone  
Office Manager