


PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

*Page 1 of 2*

FILED  
SECRETARY OF STATE  
DIVISION OF CORPORATIONS  
37 AUG 27 PM 3:12

**CORPORATION REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE  
Secretary of State  
DIVISION OF CORPORATIONS

DOCUMENT # *998000029266*

1. Corporation Name  
**MEDICAL NEUROLOGICAL ASSOCIATES, INC.**

2. Principal Office Address  
**1200 N FEDERAL HWY**

3. Mailing Office Address  
**1200 N FEDERAL HWY**

Suite, Apt. #, etc.  
**#200**

Suite, Apt. #, etc.  
**#200**

City & State  
**Boca Raton, FL**

City & State  
**Boca Raton, FL**

Zip  
**33432**

Country  
**USA**

Zip  
**33432**

Country  
**USA**

4. Date Incorporated or Qualified To Do Business in Florida **03/26/1998**

5. FEI Number **650820472**

Applied For  Not Applicable

6. CERTIFICATE OF STATUS DESIRED  \$8.75 Additional Fee required for a Certificate of Status

CR2E081 (12/05)

7. Name and Address of Current Registered Agent

Name  
**Salvatore Daddurno**

Street Address (P.O. Box Number is Not Acceptable)  
**21300 Millbrook Ct**

Suite, Apt. #, Etc.

City  
**Boca Raton**

State  
**FL**

Zip Code  
**33428**

8. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of section 607.0505 or 617.0503, F.S.

Signature of Registered Agent \_\_\_\_\_ Date **8/9/07**

REGISTERED AGENT MUST SIGN

9. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at least 3 directors)

Titles	Name of Officers and/or Directors	Street Address of Each Officer and/or Director	City / State / Zip
P/D	Salvatore Daddurno	21300 Millbrook Ct	Boca Raton, FL 33428

**REINSTATEMENT** *011-07* **000107681410**  
08/10/07--01039--008 \*\*1200.00

10. 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 contained in Chapter 119, 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]* **8/9/07** **561-350-1035**

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

*pg 2 of 2*



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**Detail by Entity Name**

**Florida Profit Corporation**

MEDICAL NEUROLOGICAL ASSOCIATES, INC.

**Filing Information**

**Document Number** P98000029266  
**FEI Number** 650820472  
**Date Filed** 03/26/1998  
**State** FL  
**Status** INACTIVE  
**Last Event** ADMIN DISSOLUTION FOR ANNUAL REPORT  
**Event Date Filed** 09/22/2000  
**Event Effective Date** NONE

*ATTN: Processor,*

**Principal Address**

1200 N PEDERA HWY  
 #200  
 BOCA RATON FL 33432  
 Changed 03/29/1999

*We did not receive notice as  
 FL Department of State did not  
 have our proper address. As such,  
 we have included a check for \$1,200.00.*

**Mailing Address**

470-N ST. RD 73  
 SUITE 221  
 FORT LAUDERDALE FL 33319  
 Changed 03/29/1999

*If there are any questions regarding  
 this filing, please contact our business consultant,  
 Rodney Kahane, at 561-362-0181.*

**Registered Agent Name & Address**

DADDURNO, DANIELLE  
 4700 NORTH STATE ROAD 7  
 SUITE 221  
 FORT LAUDERDALE FL 33319

**Officer/Director Detail**

**Name & Address**

Title D  
 MANARINO, DANIELLE  
 19329 SKYRIDGE CIRCLE  
 BOCA RATON FL 33498

*Thank you.*