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

APPLICATION FOR [redacted]

FLORIDA DEPARTMENT OF STATE
Jim Smith
Secretary of State
DIVISION OF CORPORATIONS

FILED
02 OCT 28 PM 3:12
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # **P99000042468**

1. Corporation Name

ISLON WOOLF M.D., P.A.

Principal Place of Business	Mailing Address
4302 ALTON ROAD SUITE 450 MIAMI BEACH FL 33140	4302 ALTON ROAD SUITE 450 MIAMI BEACH FL 33140

400008618604
10/28/02--01064--010 **150.00

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: **05/07/1999**

5. FEI Number: **65-0917500** ☐ 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
PDT	WOOLF, ISLON	4302 ALTON ROAD, STE. 450	MIAMI BEACH FL 33140
		02 UBC	

8. Name and Address of Current Registered Agent	9. Name and Address of New Registered Agent
WOOLF, ISLON 4302 ALTON ROAD SUITE 450 MIAMI BEACH FL 33140	Name Street Address (P.O. Box Number is Not Acceptable) Suite, Apt. #, Etc. City / State: FL / Zip Code

CR2E040 (8/02)

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 Date 10/23/2

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 REQUIRED ISLON WOOLF 10/23/2 305-534

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — PRES. — Date — Daytime Phone # 4626

PAGE 2 of 2

ISLON WOOLF, M.D.
INTERNAL MEDICINE
DIPLOMATE, AMERICAN BOARD OF INTERNAL MEDICINE

SUITE 450
4302 ALTON ROAD
MIAMI BEACH, FL 33140
(305) 534-4636

MOUNT SINAI AVENTURA
2845 AVENTURA BOULEVARD
SUITE 105
AVENTURA, FL 33180
(305) 933-9950

October 22, 2002

Division of Corporations
Annual Report/Reinstatement Section
P.O. Box 6327
Tallahassee, FL. 32314-6327

To Whom It May Concern:

Please waive my reinstatement fee for the 2002 annual report. I did not receive the two prior uniform business report notices.

Thank You,

Islon Woolf, M.D., F.A.C.P.