

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

**CORPORATION
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

10 JUN 15 PM 12:12

FILED
TALLAHASSEE, FLORIDA

DOCUMENT # **P99000050807**

1. Corporation Name
HEALTH & PHYSICAL SERVICES INC

~~W10000022028~~

400180282054
06/15/10--01019--006 **300.00

400180282054
05/04/10--01052--014 **150.00

2. Principal Office Address - No P.O. Box #

3500 N. STATE RD. 7

Suite, Apt. #, etc

190

City & State

LAUDERDALE LAKES FL

Zip

33309

Country

U.S.A.

3. Mailing Office Address

P.O. Box 212335 VILLAGE

Suite, Apt. #, etc

Royal Palm Beach

City & State

WELLINGTON FL

Zip

33414

Country

UNITED STATES

REINSTATEMENT
CRZE081 (4/10)

08-10

4. Date Incorporated or Qualified
To Do Business in Florida

6-1-1999

5. FEI Number

05-0926812

Applied For

Not Applicable

6. CERTIFICATE OF STATUS DESIRED ☐

\$8.75 Additional Fee required
for a Certificate of Status

7. Name and Address of Current Registered Agent

Name

LORNA REID

Street Address (P.O. Box Number is Not Acceptable)

9919 NW 2ND STREET

Suite, Apt. #, Etc.

City

PLANTATION

State

FL

Zip Code

33324

PROFIT CORPORATIONS ONLY

☒ The \$600.00 reinstatement fee is imposed,
except in circumstances which the entity did
not receive the prior notices. By checking
this box, you are certifying the prior
notices were not received and requesting
the reinstatement fee be waived.

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

Frank Reid

Date **4/29/10**

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
PRES	LORNA REID	13734 CHATSWORTH DR VILLAGE	WELLINGTON FL 33414
SEC	SAME AS ABOVE	SAME	SAME
TRE	SAME AS ABOVE	SAME	SAME

REINSTATEMENT

08-10

10. E-mail Address: **healthphysicalserv @ Yahoo . com**

(To be used for future annual report notification)

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. I further certify, 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:

Frank Reid

4/29/10

(61)201-5700

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #