PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT 02 DBR

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

FILED
02 NOV -5 AM 9:02
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P99000053990

1. Corporation Name

TREASURE COAST DENTAL LABORATORY, INC.

Principal Place of Business	Mailing Address
9422 S. FEDERAL HWY. PORT ST. LUCIE FL	9422 S. FEDERAL HWY. PORT ST. LUCIE FL

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: 06/14/1999

5. FEI Number: 65-0925168 ☐ 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
PD	ROSS, LAWRENCE A	8028 KIAWAH TRACE	PORT ST. LUCIE FL 34986

100008811011
11/05/02--01094--014 **150.00

8. Name and Address of Current Registered Agent	9. Name and Address of New Registered Agent
ROSS, LAWRENCE A 9422 S. FEDERAL HWY. PORT ST. LUCIE FL	Name Street Address (P.O. Box Number is Not Acceptable) Suite, Apt. #, Etc. City / State: FL / Zip Code

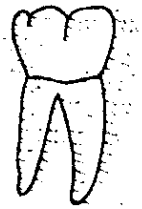
CR2E040 (8/02)

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:
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 — 10-23-02 — 772/335-5454
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #
DR. LAWRENCE A. ROSS



Treasure Coast Dental Lab

9422 South Federal Hwy.
Port St. Lucie, FL 34952
772-335-5454

October 23, 2001

Florida Department of State
Divisions of Corporations
Annual Report / Reinstatement Section
P O Box 6327
Tallahassee, FL 32314

Dear Sirs:

I respectfully request you reinstate my corporation as I did not receive the form due May 1, 2002, as I was in the hospital from April 10, to June 30, of this year.

Please see enclosed copies of statements, documenting my stay: April 10, to May 31, 2002. I was also in Holy Cross Hospital from May 31, to June 30, 2002 for which I have not received a statement to date.

Very truly yours,

Lawrence A. Ross, D.D.S., Owner of Treas. Coast Dental Lab
LAR/tls