

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

CORPORATION
REINSTATEMENT



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

FILED
SECRETARY OF STATE
DIVISION OF CORPORATIONS

00 OCT 30 PM 5:01

DOCUMENT # P99000056029

1. Corporation Name RALPH A. LEON M.D., PA

2. Principal Office Address

6107-A MEMORIAL HWY

Suite, Apt. #, etc.

City & State

TAMPA, FL

Zip

33615

Country

UNITED STATES

3. Mailing Office Address

SAME

Suite, Apt. #, etc.

City & State

4. Date Incorporated or Qualified
To Do Business in Florida

6-21-1999

5. FEI Number

59-3585387

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

RALPH A. LEON, M.D.

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

5412 WINDBRUSH DR.

Suite, Apt. #, Etc.

City

Tampa

State
FL

Zip Code

33625

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

Ralph A. Leon, M.D.
REGISTERED AGENT MUST SIGN

Date 10/24/00

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
PRESIDENT	RALPH A. LEON M.D.	5412 WINDBRUSH DR	Tampa, FL 33625

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 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:

Ralph A. Leon, M.D.
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

10/24/00

Date

913-888-4900

Daytime Phone #

CR2E081 (9/99)