

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

APPLICATION FOR



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

DOCUMENT # P99000060268

1. Corporation Name

MICHAEL CORTELLI, M.D., P.A.

Principal Place of Business

Mailing Address

5201 TPC BLVD.
LUTZ FL 33549

5201 TPC BLVD.
LUTZ FL 33549

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

07/01/1999

5. FEI Number

59-3585052

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
D	CORTELLI, MICHAEL M.D.	5201 TPC BLVD.	LUTZ FL 33549

~~688883743295~~
-02/20/01--01067--009
****300.00 ****300.00

00-01UBR 178

8. Name and Address of Current Registered Agent

CORTELLI, MICHAEL M.D.
5201 TPC BLVD.
LUTZ FL 33549

9. Name and Address of New Registered Agent

Name _____

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

Suite, Apt. #, Etc. _____

City _____ State **FL** Zip Code _____

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.

Signature of Registered Agent: *Michael Cortelli* Date: 10/23/00
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: *Michael Cortelli* Date: 10/23/00
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Daytime Phone #

CR2E040 (8/00)



CARDIOVASCULAR & THORACIC SURGICAL ASSOCIATES

MICHAEL CORTELLI, M.D.

R.R. VIJAY, M.D.
NARENDRA S. SASTRY, M.D.
IRA L. SIEGMAN, M.D.
N.S. RAITEHALLI, M.D.
MICHAEL CORTELLI, M.D.
RAVI SHARMA, M.D.

January 24, 2001

Department of State
Division of Corporations
P.O. Box 6327
Tallahassee, FL 32314

RE: Michael Cortelli, M.D., PA
FEIN: 59-3585052
DOCUMENT: P99000060268
FORM: Corporation Reinstatement

Dear Sir/Madame:

In reference to the above mentioned entity, please be aware that we never received any forms for annual filing or notification that the corporation would be dissolved.

Please accept our check in the amount of \$300.00 as payment and waive any reinstatement fees since no forms were ever received from you.

Thank you for your assistance in this matter.

Sincerely,

Michael Cortelli, M.D.