PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT

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

FILED
02 OCT 28 AM 11:10
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P99000068930

1. Corporation Name

BLANCA LUNA, M.D., P.A.

Principal Place of Business	Mailing Address
929 N. SPRING GARDENS AVE., STE. 170 DELAND FL 32720	929 N. SPRING GARDENS AVE., STE. 170 DELAND FL 32720

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: 07/28/1999

5. FEI Number: 59-3589510 ☐ 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
CEOD	LUNA, BLANCA M.D.	929 N. SPRING GARDENS AVE., STE.	DELAND FL 32720

900008636489
10/28/02 01124 002 **150.00

8. Name and Address of Current Registered Agent

LUNA, BLANCA M.D.
929 N. SPRING GARDENS AVE., STE. 170
DELAND FL 32720

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

CR2E040 (9/02)

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
REGISTERED AGENT MUST SIGN

Date: 10-21-02

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

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date: 10-21-02

Daytime Phone #

COMMUNITY MEDICAL ASSOCIATES

929 N. SpringGarden Avenue
Suite 170
Deland, FL 32720

Phone 386-738-3896
Fax 386-738-2343

October 22, 2002

Division of Corporations
Annual Report
PO Box 6327
Tallahassee, FL 32314-6327

To Whom It May Concern;
I am writing this letter to apologize with the delinquency of this payment. I did not receive a payment notice before this one, as soon as I received this one I sent out the payment. I do again apologize. If you have any questions please feel free to call me.

Thank You;

Blanca C. Luna , MD