

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

1 of 2

APPLICATION
FOR



FLORIDA DEPARTMENT OF STATE

Jim Smith

Secretary of State

DIVISION OF CORPORATIONS

DOCUMENT # P99000106597

1. Corporation Name

THE CENTER FOR EATING DISORDERS, INC.

Principal Place of Business

5850 W. ATLANTIC AVE., SUITE 101
DELRAY BEACH FL 33484

Mailing Address

5850 W. ATLANTIC AVE., SUITE 101
DELRAY BEACH FL 33484

If above addresses are incorrect in any way, line through incorrect information and enter correction below.

2. New Principal Office Address, If Applicable

Suite, Apt. #, etc.

City & State

Zip

Country

3. New Mailing Office Address, If Applicable

Suite, Apt. #, etc.

City & State

Zip

Country

✶

FILED

02 OCT 23 AM 10:30

SECRETARY OF STATE
TALLAHASSEE, FLORIDA



2002 UBR

4. Date Incorporated or Qualified
To Do Business in Florida

12/03/1999

5. FEI Number

65-1044898

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
PD	DELALLA, ELLEN M	1170 HILLSBORO MILE, SUITE 101	HILLSBORO BEACH FL 33062

000008540750
10/23/02--01013--004 **150.00

8. Name and Address of Current Registered Agent

DELALLA, ELLEN M
1170 HILLSBORO MILE, SUITE 101
HILLSBORO BEACH FL 33062

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 (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

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

Daytime Phone #

10/21/02 561-637-259

2 of 2

The Center for Eating Disorders, Inc.
5850 West Atlantic Avenue ♦ Suite 101 ♦ Delray Beach, FL 33484
Phone (561) 637-2592 ♦ Fax (561) 637-2595

October 21, 2002

To: Division of State
Division of Corporation

Re: Filing fee for 2002
Doc. #: P-99000106597

Please accept our fee for the year 2002 due in May.
We did not receive the 2002 U.B.F.

Thank you for your assistance,


Ellen DeLalla
Administrator