


PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

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<b>CORPORATION</b>		<b>FLORIDA DEPARTMENT OF STATE</b> <b>Secretary of State</b> <b>DIVISION OF CORPORATIONS</b>
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FILED

03 MAY -8 AM 11:14

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

DOCUMENT # S59695

1. Corporation Name

SARABEL RUIZ\_CESTERO, D.M.D., P.A.

2. Principal Office Address

P.O. Box 835357

Suite, Apt. #, etc.

City & State

Miami, Fl. 33283.

Zip

33283

Country

3. Mailing Office Address

Same as 2

Suite, Apt. #, etc.

City & State

Zip

Country

4. Date Incorporated or Qualified  
To Do Business in Florida

6/13/1991

5. FEI Number

65-0265284

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

Ruiz-Cestero, Sarabel

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

8500 W Flagler St # B-202

Suite, Apt. #, Etc.

Miami, Fl. 33144.

City

State  
FL

Zip Code

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

REGISTERED AGENT MUST SIGN

Date

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
D	Ruiz-Cestero, Sarabel	8500 W. Flagler St.	Miami, Fl. 33144.

02-03 UBR: ITS

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:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

4-29-2003

Date

Daytime Phone #

CR2E081 (10/02)

Sarabel Ruiz Cestero DMD, P.A.  
P.O. Box 835357  
Miami, FL 33283

Paye Wer

4-29-03

TO: Corporation  
FROM: Sarabel Ruiz-Cestero, DMD, PA  
Re: Reinstatement Application

Please correct mailing address to:

Sarabel Ruiz-Cestero, D.M.D., PA.

Mailing  
address

P.O. Box 835357

Miami, Florida

33283

Mailing address change in June 2001.

Enclose please find \$150<sup>00</sup> for 2002 d

----- \$150<sup>00</sup> for 2003.

As per conversation with Sean.

Cordially,

SRC to DMD

305-552-1971