

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION  
FOR  
REINSTATEMENT



FLORIDA DEPARTMENT OF STATE  
Glenda E. Hood  
Secretary of State  
DIVISION OF CORPORATIONS

FILED

03 OCT 22 PM 4:57

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

DOCUMENT # **S85656**

1. Corporation Name

**HEMOCARE OF SOUTH FLORIDA, INC.**

Principal Place of Business

Mailing Address

4564 MARKS WAY  
LAKE WORTH FL 33463

4564 MARKS WAY  
LAKE WORTH FL 33463

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

10/07/1991

5. FEI Number

65-0291145

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
D	FLYNN, BARBARA ANN	4564 MARKS WAY	LAKE WORTH FL

500024012685  
10/22/03--01043--004 \*\*750.00

8. Name and Address of Current Registered Agent

9. Name and Address of New Registered Agent

FLYNN, BARBARA ANN  
4564 MARKS WAY  
LAKE WORTH FL 33463

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. or 617.0505, F.S.

Signature of  
Registered Agent

*Barbara Flynn*  
REGISTERED AGENT MUST SIGN

Date 10-17-03

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:

*Barbara Flynn*  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

10-17-03

Date

Daytime Phone #

CR2E040 (7/03)