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 21 PM 12:08
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # **V38638**

1. Corporation Name

CRITICAL CARE OF NORTH JACKSONVILLE, P.A.

Principal Place of Business	Mailing Address
3550 UNIVERSITY BLVD SO SUITE 207 JACKSONVILLE FL 32256 US	3550 UNIVERSITY BLVD SO SUITE 207 JACKSONVILLE FL 32256 US

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: **05/26/1992**

5. FEI Number: **59-3123948** ☐ 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
DP	JACKLER, IRA M	2204 ACADIE DR	JACKSONVILLE FL
ST	JACKLER, EVA V.	2204 ACADIE DR	JACKSONVILLE FL

200023970892
10/21/03--01062--022 **150.00

8. Name and Address of Current Registered Agent	9. Name and Address of New Registered Agent
JACKLER, IRA M. POST OFFICE BOX 56917 JACKSONVILLE FL 32241	Name Street Address (P.O. Box Number is Not Acceptable) Suite, Apt. #, Etc. City / State: FL / Zip Code

CR2E040 (7/03)

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 _____ Date 10/14/03
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: _____ 10/14/03 (904) 739-6666
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

Critical Care of North Jacksonville, P.A.

Ira M. Jackler. M.D.
Board Certified
Internal Medicine
Pulmonary Medicine/Critical Care

Amit Chakravarty, M.D.
Board Certified
Internal Medicine
Pulmonary Medicine/Critical Care

October 14, 2003

Dear Sirs:

Enclosed you will find a check for $150.00. We did not reveive the annual report notice. With this in account please wave the reinstatement fee.

Thank you very much.

Sincerely,

Eva

Eva Jackler
EJ/cs

3550 University Boulevard, South ■ Suite 207 ■ Jacksonville, Florida 32216
Phone (904) 739-6666 Fax (904) 739-1009