

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

10f2

~~APPLICATION FOR REINSTATEMENT~~



FLORIDA DEPARTMENT OF STATE
 Statewide Harris
 Secretary of State
 DIVISION OF CORPORATIONS

FILED

00 OCT 24 AM 11:40

SECRETARY OF STATE
 TALLAHASSEE FLORIDA

DOCUMENT # J01007

1. Corporation Name

INDEPENDENT MEDICAL AND DENTAL CONSULTANTS, INC

Principal Place of Business

Mailing Address

36 W. RT. 70, PO BOX 448
 SUITE 214
 MARLTON NJ 08053
 US

36 W. RT. 70, PO BOX 448
 SUITE 214
 MARLTON NJ 08053
 US

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



KE

2. New Principal Office Address, If Applicable

3. New Mailing Office Address, If Applicable

4. Date Incorporated or Qualified To Do Business in Florida

02/24/1986

Suite, Apt. #, etc.

Suite, Apt. #, etc.

5. FEI Number

22-2436812

Applied For

Not Applicable

City & State

City & State

Zip

Country

Zip

Country

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
S	GROSS, DEBRA	36 W. RT 70, STE. 214, PO BOX 448	MARLTON NJ 08053
TD	MORGENROTH, HERBERT B.	36 W. RT 70, STE. 214, PO BOX 448	MARLTON NJ 08053
PVP	GROSS, DEBRA	36 W. RT 70, STE. 214, PO BOX 448	MARLTON NJ 08053

900003459179--3
 -11709/00--01085--004
 ***150.00 ***150.00

8. Name and Address of Current Registered Agent

9. Name and Address of New Registered Agent

LIEBERMAN, KAREN
 10515 N.W. 11TH CT
 PLANTATION FL 33322

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.

Signature of Registered Agent

Karen Lieberman

Date 10/20/00

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:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR
 DR. HERBERT B. MORGENROTH

10/18/00
 Date

856-596-8100
 Daytime Phone #

CR2E040 (8/00)

IMDC

Independent Medical and Dental Consultants

282

Home Office: 36 West Route 70
Suite 214
PO Box 448
Marlton, NJ 08053

October 18, 2000

RE: #J01007
INDEPENDENT MEDICAL AND DENTAL CONSULTANTS

To Whom It May Concern:

Enclosed please find a copy of check #46265, in the amount of \$150.00, which was sent overnite but never received or cashed.

When we received an application for reinstatement, I called and spoke with Leslie and she informed me that our check was not received or recorded. I was told to send this letter of explanation along with the reinstatement application and a new check for \$150.00.

Please acknowledge receipt and reinstatement of Independent Medical and Dental Consultants.

Thank you for your attention to this matter.

Sincerely,

Lisa Foster

Lisa Foster,
Accounting Supervisor