

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM. 1 of 2

**APPLICATION FOR REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE  
**Sandra B. Mortham**  
 Secretary of State  
 DIVISION OF CORPORATIONS

**FILED**

97 APR -9 AM 11:17

SECRETARY OF STATE  
 TALLAHASSEE FLORIDA

DOCUMENT # **P93000058787**

1. Corporation Name  
**ECLIPSE HEALTHCARE, INC.**

|  |   |
|--|---|
| Principal Place of Business<br>7020 CHIPPEWA ST.<br>ST. LOUIS MO 63119 | Mailing Address<br>% MAT MADISON TURNER<br>9939 GRAVOIS RD.<br>ST. LOUIS MO 63123 |
|--|---|

**REINSTATEMENT** 00 96-97

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 |  | 4. Date Incorporated or Qualified To Do Business in Florida |  |
| Suite, Apt. #, etc.                                       |  | Suite, Apt. #, etc.                          |  | 08/18/1993  |  |
| City & State  |  | City & State                                 |  | 5. FEI Number   |  |
| Zip   |  | Zip  |  | 59-3196515  |  |
| Country   |  | Country                                      |  | Applied For   |  |
|   |  |  |  | Not Applicable  |  |
| 6. CERTIFICATE OF STATUS DESIRED <input type="checkbox"/> |  |  |  | \$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 (Do NOT Use Post Office Box Numbers) | 4 City / State / Zip |
|------------|-------------------------------------|---|----------------------|
| PSD        | SERAFIN, KATHLEEN                   | 7020 CHIPPEWA ST.   | ST. LOUIS MO 63119   |
|            |                                     |   |                      |
|            |                                     |   |                      |
|            |                                     |   |                      |
|            |                                     |   |                      |

000002139540--5  
 -04/10/97--01086--009  
 \*\*\*\*\*915.00 \*\*\*\*\*915.00

|   |  |  |          |
|---|--|--|----------|
| 8. Name and Address of Current Registered Agent                         |  | 9. Name and Address of New Registered Agent        |          |
| CT CORPORATION SYSTEM<br>1200 S. PINE ISLAND RD.<br>PLANTATION FL 33324 |  | Name   |          |
|   |  | Street Address (P.O. Box Number is Not Acceptable) |          |
|   |  | Suite, Apt. #, Etc.                                |          |
|   |  | City   |          |
|   |  | State  | Zip Code |
|   |  | FL   |          |

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: **SEE ATTACHMENT** Date: \_\_\_\_\_

REGISTERED AGENT MUST SIGN

11. Does this corporation pay any intangible tax to the Dept. of Revenue under S. 199.032, Florida Statutes. Yes  No  (See other side for information on Intangible tax.)

12. 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)(l), 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: *Kathleen Serafin* Date: **3/28/97** Daytime Phone # \_\_\_\_\_

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

CR2E040 (7/95)

**ACCEPTANCE OF APPOINTMENT**

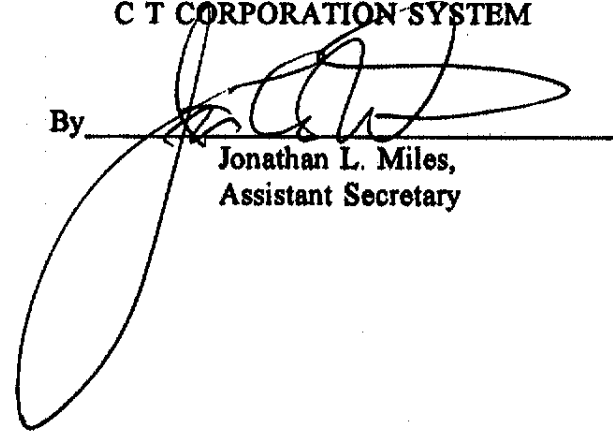
**RE: ECLIPSE HEALTHCARE, INC. (FL DOM)**

Pursuant to Sections 48.091 and 607.0501, Florida Statutes, the undersigned acknowledges and accepts its appointment as registered agent of the above corporation and agrees to act in the capacity and to comply with the provisions of the Florida Business Corporation Act (1990) relative to keeping open the registered office at the address specified above. The undersigned is familiar with, and accepts the obligations of, Section 607.0505, Florida Statutes.

Dated: March 7, 1997

**C T CORPORATION SYSTEM**

By \_\_\_\_\_

A large, stylized handwritten signature in black ink, written over a horizontal line. The signature is cursive and appears to read 'Jonathan L. Miles'. A large, vertical loop extends from the bottom of the signature.

**Jonathan L. Miles,  
Assistant Secretary**