

2006 LIMITED LIABILITY COMPANY REINSTATEMENT

DOCUMENT # L02000017263

1. Entity Name
MAIL ORDER MEDS OF FLORIDA, LLC



FILED
SECRETARY OF STATE
DIVISION OF CORPORATIONS

06 DEC 29 AM 8:29

Principal Place of Business 4500 BISCAYNE BLVD. SUITE # 104 MIAMI, FL 33137	Mailing Address 4500 BISCAYNE BLVD. SUITE # 104 MIAMI, FL 33137
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2. Principal Place of Business Suite, Apt. #, etc.	3. Mailing Address Suite, Apt. #, etc.
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City & State	City & State
Zip	Country

12112006 REIN-LLC CR2E101 (11/05)

4. FEI Number
04-3702637

5. Certificate of Status Desired **\$5.00 Additional Fee Required**

6. Name and Address of Current Registered Agent

**FILINGS, INC.
3732 NORTHWEST 16TH STREET
FORT LAUDERDALE, FL 33311**

7. Name and Address of New Registered Agent

Name

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

City **FL** Zip Code

8. The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. I am familiar with, and accept the obligations of registered agent.

SIGNATURE _____ (NOTE: Registered Agent signature required when reinstating) DATE _____

FILE NOW!!! FEE IS \$50.00 After January 1, 2007, Fee will be \$100.00	In accordance with s. 607.193(2)(b), F.S., the limited liability company did not receive the prior notice.	Make check payable to Florida Department of State
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9. MANAGING MEMBERS/MANAGERS	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM ALLION HEALTHCARE, INC. (A DEL. CORP.) 4500 BISCAYNE BLVD, SUITE 104 MIAMI, FL 33137 <input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM MORAN, MICHAEL P 4500 BISCAYNE BLVD, SUITE 104 MIAMI, FL 33137 <input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete

10. ADDITIONS/CHANGES	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM ALLION HEALTHCARE, INC 1660 WALT WHITMAN RD SUITE 105 MELVILLE NY 11747 <input checked="" type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM MORAN MICHAEL P. 1660 WALT WHITMAN RD SUITE 105 MELVILLE NY 11747 <input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	300082816093 12/28/06--01018--022 **50.00
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition

11. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Chapter 119, Florida Statutes. I further certify that the information indicated on this report is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am a managing member or manager of the limited liability company or the receiver or trustee empowered to execute this report as required by Chapter 60B, Florida Statutes.

SIGNATURE: Jana G. Spurr Date: 12/12/06 Daytime Phone #: 6318705126

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE