PLEASE READ ALL INSTRUCTIONS BEFORE

FILED

13 AUG -5 PM 2:28

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

LIMITED LIABILITY COMPANY REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # L11000056545

1. Limited Liability Company's Name
Cambridge Healthcare Solutions LLC

100250486521

CR2E041 (1/11)

2. Principal Office Address - No P.O. Box #	3. Mailing Office Address
4501 Gulf Shore Boulevard North	4501 Gulf Shore Boulevard North
Suite, Apt. #, etc.: PH 1503	Suite, Apt. #, etc.: PH 1503
City & State: Naples, FL	City & State: Naples, FL
Zip: 34103 Country:	Zip: 34103 Country:

4. State/Country of Formation: Florida

5. Date Organized or Qualified To Do Business in Florida: May 12, 2011

6. FEI Number: 45-2598563 ☐ Applied For ☐ Not Applicable

7. CERTIFICATE OF STATUS DESIRED ☐ $5.00 Additional Fee required for a Certificate of Status

8. Name and Address of Current Registered Agent

Name: Andrew J. Czekaj

Street Address (P.O. Box Number is Not Acceptable): 4501 Gulf Shore Boulevard North

Suite, Apt. #, Etc.: PH 1503

City: Naples State: FL Zip Code: 34103

E-mail Address: cchannell@cambridgeus.com
(To be used for future annual report notices)

9. I, being appointed the registered agent of the above named limited liability company, am familiar with and accept the obligations of Chapter 608, F.S.

Signature of Registered Agent _____ Date 8/5/13
REGISTERED AGENT MUST SIGN

10. Names and Street Addresses of Managing Members/Managers

Titles	Name of Managing Members/ Managers	Street Address of Each Managing Member/ Manager	City / State / Zip
MGR	Andrew J. Czekaj	4501 Gulf Shore Blvd N, #1503	Naples, FL 34103

REINSTATEMENT

11-13

11. I certify that I am managing member/manager or the receiver or trustee empowered to execute this application as provided for in Chapter 608, F.S. I further certify that when filing this reinstatement application the reason for dissolution has been eliminated, the limited liability company name satisfies the requirements of section 608.406, F.S., and that all fees owed by the limited liability company have been paid. The information indicated on this application is true and accurate, and my signature shall have the same legal effect as if made under oath. I am aware that false information submitted in a document to the Department of State constitutes a third degree felony as provided for in s.817.155, F.S.

Signature of Managing Member/Manager _____ Date 8/5/13 Daytime Phone # 703-709-8868

Typed or printed name of signing Managing Member/Manager: Andrew J. Czekaj, Manager

8/5

CORPORATION SERVICE COMPANY

ACCOUNT NO. : I20000000195

REFERENCE : 750786 7569274

AUTHORIZATION :

COST LIMIT : $ 377.50

ORDER DATE : August 2, 2013

ORDER TIME : 10:21 AM PLEASE FILE 1ST**

ORDER NO. : 750786-030

CUSTOMER NO: 7569274

RECEIVED
DEPARTMENT OF STATE
13 AUG -6 AM 10:53

DOMESTIC FILINGS

NAME: CAMBRIDGE HEALTHCARE SOLUTIONS LLC

XX REINSTATEMENT

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

_____ CERTIFIED COPY
XX PLAIN STAMPED COPY
_____ CERTIFICATE OF GOOD STANDING

CONTACT PERSON: Susie Knight - Ext# 52956

EXAMINER'S INITIALS _____