


PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

1 of 2

**CORPORATION REINSTATEMENT**



**FLORIDA DEPARTMENT OF STATE**  
Secretary of State  
DIVISION OF CORPORATIONS

FILED  
06 SEP 10 12:51  
TALLAHASSEE

DOCUMENT # P02000017880

1. Corporation Name  
**Preferred Medical Services, Inc.**

2. Principal Office Address <b>9000 SW 87 Ct.</b>		3. Mailing Office Address <b>P.O. Box 560130</b>	
Suite, Apt. #, etc. <b>Suite 219</b>		Suite, Apt. #, etc.	
City & State <b>Miami FL</b>		City & State <b>Miami FL</b>	
Zip <b>33176</b>	Country <b>USA</b>	Zip <b>33256</b>	Country <b>USA</b>

**REINSTATEMENT 03-06**  
CR2E081 (12/05)

4. Date Incorporated or Qualified To Do Business in Florida **2-13-02**

5. FEI Number **04-3606898** Applied For  Not Applicable

6. CERTIFICATE OF STATUS DESIRED  \$8.75 Additional Fee required for a Certificate of Status

7. Name and Address of Current Registered Agent

Name **Denise Matarangolo**

Street Address (P.O. Box Number is Not Acceptable)  
**9000 SW 87 Ct.**

Suite, Apt. #, Etc. **Suite 219**

City **Miami** State **FL** Zip Code **33176**

8. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of section 607.0505 or 617.0503, F.S.

Signature of Registered Agent **Denise** Date **9-11-06**

REGISTERED AGENT MUST SIGN

9. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at least 3 directors)

Titles	Name of Officers and/or Directors	Street Address of Each Officer and/or Director	City / State / Zip
P/M/D	Denise Matarangolo	9000 SW 87 Ct. 219	Miami, FL 33176

5100080387285  
10/02/06--01023--009 \*\*\$08.75

10. 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 contained in Chapter 119, 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: **Denise** Date **9-11-06** Daytime Phone # **305-630-9244**

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

2052

## PREFERRED MEDICAL SERVICES, INC.

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P.O. Box 560130  
Miami Fl. 33256

Phone: 305-630-9244  
Fax: 305-630-9223

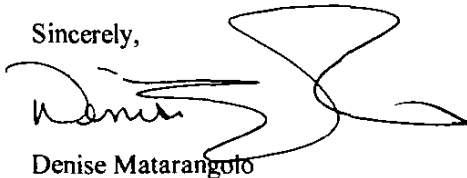
September 11, 2006

Department of State  
Division of Corporations  
P.O. Box 6327  
Tallahassee, FL 32314

To whom it may concern,

This letter is to inform you that we would like the following company to be reinstated. Preferred Medical Services, Inc. document number P02000017880. We never received the annual report due to the fact that it went to the wrong address 13615 South Dixie Highway, #114-514, Miami, FL 33176. I am correcting the address on the reinstatement form. I was also informed to send a check in the amount of \$600.00 which I have enclosed. Thank you for your help on this matter.

Sincerely,



Denise Matarangolo