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 MAR -3 PM 1:25
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P98000066490

1. Corporation Name

SUNSHINE MEDICAL CENTER OF DESTIN, INC.

500067939185
03/16/06--01003--011 **600.00

REINSTATEMENT 03-06

CR2E081 (8/05)

2. Principal Office Address		**3.** Mailing Office Address	
350 BLUE MT. BEACH RD.		2213 STERLINGWOOD DR	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State: SANTA ROSA BEACH FL		City & State: BIRMINGHAM AL	
Zip: 32459	Country:	Zip: 35243-1756	Country:

4. Date Incorporated or Qualified To Do Business in Florida

5. FEI Number: 593551701 ☐ 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: VALENTINA ALDRETE

Street Address (P.O. Box Number is Not Acceptable): 350 BLUE MT. BEACH RD.

Suite, Apt. #, Etc.:

City: SANTA ROSA BEACH | State: FL | Zip Code: 32459

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: _____ Date: 02/16/06

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
DP	J ANTONIO ALDRETE	350 BLUE MT. BEACH RD.	SANTA ROSA BEACH FL 32459
DVP	VALENTINA ALDRETE	350 BLUE MT. BEACH RD.	SANTA ROSA BEACH FL 32459

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 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: _____ J ANTONIO ALDRETE — 2/15/2006 — 205-968-0068

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

2 of 2

DATE: 02-15-2006

TO: **DEPARTMENT OF STATE**
DIVISION OF CORPORATIONS

FROM: **SUNSHINE MEDICAL CENTER OF DESTIN, INC.**
VALENTINA ALDRETE

WE DID NOT RECEIVE FROM YOU THE UNIFORM BUSINESS REPORT FOR 2003, 2004 AND 2005.

PLEASE FILE OUR ANNUAL REPORT AND WAIVE THE PENNALTY.

IF YOU HAVE ANY QUESTIONS PLEASE CONTACT US AT 205-968-0068.

THANKS,

SUNSHINE MEDICAL CENTER OF DESTIN, INC.
VALENTINA ALDRETE
DIRECTOR, VICE-PRESIDENT