

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

1 of 2

**CORPORATION
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # P98000066490

1. Corporation Name

SUNSHINE MEDICAL CENTER OF DESTIN, INC.

2. Principal Office Address

350 BLUE MT. BEACH RD.

Suite, Apt. #, etc.

3. Mailing Office Address

2213 STERLINGWOOD DR

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

REINSTATEMENT 03-06
CR2E081(8/05)

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

FILED
06 MAR -3 P:11:25
SECRET
TALLAHASSEE, FLORIDA

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

REGISTERED AGENT MUST SIGN

Date

02/16/06

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

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

J ANTONIO ALDRETE

2/15/2006

Date

205-968-0068

Daytime Phone #

2002

DATE: 02-15-2006

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

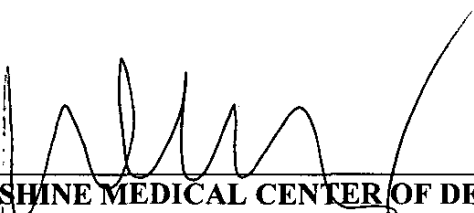
FROM: **SUNSHINE MEDICAL CENTER OF DESTIN, INC.**
VALENTINA ALDRETE

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