PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT 02 CBR

FLORIDA DEPARTMENT OF STATE
Jim Smith
Secretary of State
DIVISION OF CORPORATIONS

FILED
02 NOV 20 AM 10:57
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P01000107680

1. Corporation Name

TRI-CARE REHABILITATION, INC.

Principal Place of Business	Mailing Address
2200 EAST IRLO BRONSON HWY. 192 ~~SUITE 107~~ KISSIMMEE FL 34744	2200 EAST IRLO BRONSON HWY. 192 ~~SUITE 107~~ KISSIMMEE FL 34744

If above addresses are incorrect in any way, line through incorrect information and enter correction below.

2. New Principal Office Address, If Applicable	3. New Mailing Office Address, If Applicable
~~2200 East Irlo Bronson Hwy~~ #a	Suite 103
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State	City & State
Zip / Country	Zip / Country

4. Date Incorporated or Qualified To Do Business in Florida: 11/07/2001

5. FEI Number: 59-3760592 ☐ Applied For ☐ Not Applicable

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

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

Title(s) 1	Name of Officers and/or Directors 2	Street Address of Each Officer and/or Director 3	City / State / Zip 4
PTD	NELSON, MARYSE A	804 MENDOZA DRIVE	KISSIMMEE FL 34758

100009113381
11/20/02--01068--016 **150.00

8. Name and Address of Current Registered Agent	9. Name and Address of New Registered Agent
NELSON, MARYSE A 804 MENDOZA DRIVE KISSIMMEE FL 34758	Name Street Address (P.O. Box Number is Not Acceptable) Suite, Apt. #, Etc. City / State FL / Zip Code

CR2E040 (8/02)

10. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of Section 607.0505, F.S. or 617.0505, F.S.

Signature of Registered Agent: SIGNATURE REQUIRED — Date: 11/02/02
REGISTERED AGENT MUST SIGN

11. 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 REQUIRED — 11/02/02 — 407-847-0900
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

TRI-CARE REHABILITATION, INC.

2200 E IRLO BRONSON HWY., STE 103
KISSIMMEE, FL 34744
407-847-0900 FAX 407-847-0030 EMAIL tricare@aol.com

Division of Corporations
Annual Report/Reinstatement Section
P.O. Box 6327
Tallahassee, FL 32314-6327

November 02, 2002

To Whom It May Concern:

In response to the reinstatement package we received, this is to inform you that we never received your initial correspondence. I called your office and spoke with a representative who informed me that due to an address error, your initial letter was returned to you. I was advised to send this letter along with the 150 dollar fee in order to have my company reinstated.

Please note that the correct suite number for Tri-Care is #103 and not #107. I thank you in advance for your understanding and please do not hesitate to contact us with any questions.

Sincerely Yours,

Maryse A. Nelson, LPT, MBA
Clinical Director