PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Katherine Harris
Secretary of State
DIVISION OF CORPORATIONS

FILED
SECRETARY OF STATE
DIVISION OF CORPORATIONS
00 NOV 14 PM 1:25

DOCUMENT # G08511

1. Corporation Name

HOMECARE MEDICAL ASSOCIATES, INC.

Principal Place of Business	Mailing Address
6600 N.W. 12TH AVENUE #217 FT LAUDERDALE FL 33309-1147	6600 N.W. 12TH AVENUE #217 FT LAUDERDALE FL 33309-1147

REINSTATEMENT 00

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	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country

4. Date Incorporated or Qualified To Do Business in Florida: 11/10/1982

5. FEI Number: 59-2247655 — 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
PST	GUTIERREZ, JULIO J	6600 NW 12 AVE #217	FT. LAUDERDALE FL
VD	GUTIERREZ, MARIA L	6600 NW 12 AVE #217	FT. LAUDERDALE FL
D	GUTIERREZ, JULIO J	6600 NW 12 AVE #217	FT. LAUDERDALE FL
V	SOLOGUREN, LUIS	6600 NW 12 AVE #217	FT. LAUDERDALE FL
			400003496924--2 -12/12/00--01045--014 ****750.00 ****750.00

8. Name and Address of Current Registered Agent	9. Name and Address of New Registered Agent
SOLOGUREN, LUIS R JR. 6600 NW 12 AVE SUITE 217 FT. LAUDERDALE FL 33309	Name Street Address (P.O. Box Number is Not Acceptable) Suite, Apt. #, Etc. City / State: FL / Zip Code

CR2E040 (8/00)

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.

Signature of Registered Agent: [signature] Date: 11/7/00
REGISTERED AGENT MUST SIGN

11. I certify that I am an officer or director of 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] 10/19/00 AD 954-952-9003
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #