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SECRETARY OF STATE
TALLAHASSEE, FLORIDA

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

LIMITED LIABILITY COMPANY REINSTATEMENT		 FLORIDA DEPARTMENT OF STATE Jim Smith Secretary of State DIVISION OF CORPORATIONS	
DOCUMENT # L01000002999			
1. Limited Liability Company's Name GMS HEALTHCARE OF GEORGIA, LLC			
2. Principal Office Address 10008 N. DALE MABRY HIGHWAY		3. Mailing Office Address 10008 N. DALE MABRY HIGHWAY	
Suite, Apt. #, etc. SUITE 214		Suite, Apt. #, etc. SUITE 214	
City & State TAMPA, FLORIDA		City & State TAMPA, FLORIDA	
Zip 33618	Country USA	Zip 33618	Country USA
4. State/Country of Formation FLORIDA		5. Date Organized or Qualified To Do Business in Florida 02/27/2001	
6. FEI Number		Applied For ☐ Not Applicable ☐	
7. CERTIFICATE OF STATUS desired ☒ \$1.00 Additional Fee per page for 25 or more pages			

8. Name and Address of Current Registered Agent	
Name SAM D. TONEY, M.D.	
Street Address (P.O. Box Number is Not Acceptable) 10008 N. DALE MABRY HIGHWAY	
Suite, Apt. #, Etc. SUITE 214	
City TAMPA	
State FL	Zip Code 33618

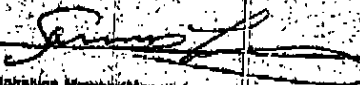
9. I, being appointed the registered agent of the above named limited liability company, am familiar with and accept the obligations of Chapter 608, F.S.

Signature of Registered Agent _____ Date _____

REGISTERED AGENT MUST SIGN

10. Names and Street Addresses of Managing Members/Managers			
Title	Name of Managing Member/Manager	Street Address of Each Managing Member/Manager	City / State / Zip
MGRM	SAM D. TONEY, M.D.	10008 N. DALE MABRY HY, ST 214	TAMPA, FLORIDA 33618
MGRM	SHAN PADOA	10008 N. DALE MABRY HY, ST 214	TAMPA, FLORIDA 33618

11. I certify that I am managing member/manager or the receiver or liquidator of the company and I am authorized to execute this application as provided for in chapter 608, F.S. I further certify that when this reinstatement application is filed, the reason for dissolution has been dissolved; the limited liability company name satisfies the requirements of section 608.406, F.S., and that all fees owed by the limited liability company have been paid. 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 of Managing Member/Manager:  Date: **2/11/08** Daytime Phone: **813 264-7577**

Typed or printed name of signing Managing Member/Manager: _____