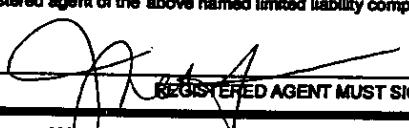
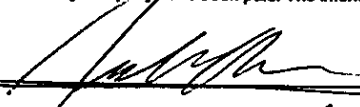


PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

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LIMITED LIABILITY COMPANY REINSTATEMENT- <u>LLCR</u>		FLORIDA DEPARTMENT OF STATE Jim Smith Secretary of State DIVISION OF CORPORATIONS	
DOCUMENT # L01000014014			
1. Limited Liability Company's Name SOUTH FLORIDA MEDICAL PAIN RELIEF CENTER, LLC			
2. Principal Office Address 4473 N. STATE ROAD 7 Suite, Apt. #, etc.		3. Mailing Office Address 4473 N. STATE ROAD 7 Suite, Apt. #, etc.	
City & State LAUDERDALE LAKES, FL		City & State LAUDERDALE LAKES, FL	
Zip 33319	Country USA	Zip 33319	Country USA
4. State/Country of Formation FLORIDA		5. Date Organized or Qualified To Do Business in Florida AUGUST 20, 2001	
6. FEI Number 65-1132665		Applied For Not Applicable	
7. CERTIFICATE OF STATUS DESIRED ☐		\$5.00 Additional Fee required for a Certificate of Status	
8. Name and Address of Current Registered Agent			
Name JENNIFER L. SCHECHTMAN, CPA			
Street Address (P.O. Box Number is Not Acceptable) 9050 PINES BLVD			
Suite, Apt. #, Etc. SUITE 205			
City PEMBROKE PINES,			
State FL		Zip Code 33024	
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 NOVEMBER 4, 2002	
REGISTERED AGENT MUST SIGN			
10. Names and Street Addresses of Managing Members/Managers			
Titles	Name of Managing Members/Managers	Street Address of Each Managing Member/Manager	City / State / Zip
MGR	ANDRES OLEA	4473 N. STATE ROAD 7	LAUDERDALE LAKES, FL 33319
MGR	CHARLA SANTAMARIA	4473 N. STATE ROAD 7	LAUDERDALE LAKES, FL 33319
MGR	JERRY DUBRAVETZ	4473 N. STATE ROAD 7	LAUDERDALE LAKES, FL 33319
11. I certify that I am managing member/manager or the receiver or trustee empowered to execute this application as provided for in chapter 608, F.S. I further certify that when filing this reinstatement application the reason for dissolution has been eliminated, 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 11-1-02	
Typed or printed name of signing Managing Member/Manager ANDRES OLEA		Daytime Phone # 954 410 3320	

CR20041 (8/01)

20/2

L01000014014

SOUTH FLORIDA MEDICAL P.R.C. INC.

4473 NORTH STATE ROAD 7 (441)
LAUDERDALE LAKES, FL 33319
OFFICE (954) 714-8848 FAX (954)966-3352

November 1, 2002

Division of Corporations
Registration Section
P.O. Box 6327
Tallahassee, Florida 32314

FILED
02 NOV 13 PM 4:23
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

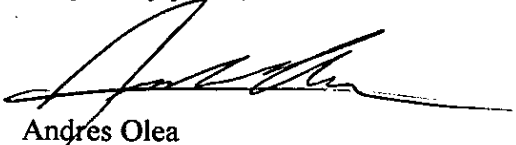
RE: SOUTH FLORIDA MEDICAL PAIN RELIEF CENTER, LLC
FEIN #65-1132665

Dear Sir or Madam:

Enclosed please find a Limited Liability Company Reinstatement form for South Florida Medical Pain Relief Center, LLC. The company never received the UBR Form for 2002. I called your office to discuss this problem. Please find enclosed a check in the amount of \$150 for the year 2002.

I want to thank you for all the help that was given to me. If you have any questions, Please contact me at the above telephone number.

Very Truly yours,



Andres Olea

AO/ytq

BF