PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

LIMITED LIABILITY COMPANY REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

FILED
2009 NOV -3 PM 3:55
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

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CR2E041 (10/08)

DOCUMENT # L01000020487

1. Limited Liability Company's Name

Tampa Medical & Rehab Care, LLC

2. Principal Office Address - No P.O. Box #		**3.** Mailing Office Address	
4107 N. Himes Ave.		4107 N. Himes Ave.	
Suite, Apt. #, etc. 101		Suite, Apt. #, etc. 101	
City & State Tampa, Florida		City & State Tampa, Florida	
Zip 33607	Country USA	Zip 33607	Country USA

4. State/Country of Formation: Florida

5. Date Organized or Qualified To Do Business in Florida: 2001

6. FEI Number: 59-3755780 ☐ 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: Ycaza, Luis F.

Street Address (P.O. Box Number is Not Acceptable): 4107 N. Himes Ave.

Suite, Apt. #, Etc.: 101

City: Tampa | State: FL | Zip Code: 33607

☐ A $100 reinstatement fee is imposed, except in circumstances which the entity did not receive the prior notices. By checking this box, you are certifying the prior notices were not received and requesting the $100 reinstatement be waived.

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: LLY Date: 10-27-09

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
MGRM	Ycaza, Luis F.	4107 N. Himes Ave.#101	Tampa FL 33607
		REINSTATEMENT 08-09	

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: LLY Date: 10-27-09 Daytime Phone # 813-877-8177

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