

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

LIMITED LIABILITY  
COMPANY  
REINSTATEMENT



FLORIDA DEPARTMENT OF STATE  
Secretary of State  
DIVISION OF CORPORATIONS

FILED  
07 JUL -2 PM 2:17  
SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

DOCUMENT # L 02000004303

1. Limited Liability Company's Name

A. GIROUARD LLC

2. Principal Office Address - No P.O. Box #

1ST JOHNS MEDICAL PARK

Suite, Apt. #, etc.

Drive Suite A

City & State

ST Augustine FL

Zip

32086

Country

USA

3. Mailing Office Address

Same

Suite, Apt. #, etc.

City & State

Zip

Country

4. State/Country of Formation

FLORIDA / USA

5. Date Organized or Qualified  
To Do Business in Florida

Feb 22nd, 2002

6. FE Number

020552646

Applied For

Not Applicable

7. CERTIFICATE OF STATUS DESIGNATION

NO \$100 Additional Fee required  
for a Certificate of Status

8. Name and Address of <sup>New</sup> Current Registered Agent

Name

ALLAIN GIROUARD

Street Address (P.O. Box Number is Not Acceptable)

1ST JOHNS MEDICAL PARK DR.

Suite, Apt. #, Etc.

Suite A

City

ST Augustine

State

FL

Zip Code

32086

☐ 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

Date 6.19.07

REGISTERED AGENT MUST SIGN

10. Names and Street Addresses of Managing Members/Managers

| Titles | Name of<br>Managing Members/Managers | Street Address of Each<br>Managing Member/Manager | City / State / Zip |
|--------|--------------------------------------|---------------------------------------------------|--------------------|
| P/MGR  | ALLAIN GIROUARD                      | Same as above                                     |                    |
| T      | ALLAIN GIROUARD                      | Same as above                                     |                    |
| S      | ALLAIN GIROUARD                      | Same as above                                     |                    |
|        |                                      |                                                   |                    |
|        |                                      |                                                   |                    |
|        |                                      |                                                   |                    |
|        |                                      |                                                   |                    |
|        |                                      |                                                   |                    |
|        |                                      |                                                   |                    |

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REINSTATEMENT

03-07

BA

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 6.19.07

Daytime Phone #

904-797 7463

Typed or printed name of signing Managing Member/Manager

ALLAIN GIROUARD MD