


PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

LIMITED LIABILITY COMPANY REINSTATEMENT		 FLORIDA DEPARTMENT OF STATE Secretary of State DIVISION OF CORPORATIONS		FILED 10 APR -9 PM 12:56 SECRETARY OF STATE TALLAHASSEE, FLORIDA 700173211297 03/26/10--01014--002 **416.25 CR2E041 (11/09)	
DOCUMENT # L03 0000379.31					
1. Limited Liability Company's Name MEDICAL TOYS, LLC.					
2. Principal Office Address - No P.O. Box # 1105 Casey Key Rd Suite, Apt. #, etc.		3. Mailing Office Address 1105 Casey Key Rd. Suite, Apt. #, etc.			
City & State Nokomis, FL Zip 34275 Country USA		City & State Nokomis, FL Zip 34275 Country USA		4. State/Country of Formation Florida	
				5. Date Organized or Qualified To Do Business in Florida 10/06/03	
				6. FEI Number 20-0541877 Applied For <input type="checkbox"/> Not Applicable <input checked="" type="checkbox"/>	
				7. CERTIFICATE OF STATUS DESIRED <input type="checkbox"/> \$5.00 Additional Fee required for a Certificate of Status	
8. Name and Address of Current Registered Agent					
Name Kenneth D. Doerr					
Street Address (P.O. Box Number is Not Acceptable) 22 Links Ave., Suite 300					
Suite, Apt. #, Etc.					
City Sarasota,		State FL		Zip Code 34234	
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 [Signature]				Date 3-24-10	
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	Christopher D. Brukoff	1105 Casey Key Rd,	Nokomis, FL 34275		
REINSTATEMENT 08-10 [Signature]					
11. E-mail Address: _____					
(To be used for future annual report notifications)					
12. 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 [Signature]		Date 3/10/10		Daytime Phone # 941-320-7139	
Typed or printed name of signing Managing Member/Manager _____					