PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

LIMITED LIABILITY COMPANY REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

FILED
2009 DEC 24 PM 1:23
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # L04000026814

1. Limited Liability Company's Name

EMERGENCY MEDICAL SOLUTIONS, LLC

CR2E041 (11/09)

2. Principal Office Address - No P.O. Box #	3. Mailing Office Address
2727 SHADE TREE DR.	2727 SHADE TREE DR.
Suite, Apt. #, etc. —	Suite, Apt. #, etc. —
City & State: FLEMING ISLAND, FL.	City & State: FLEMING ISLAND, FL.
Zip: 32003 Country: USA	Zip: 32003 Country: USA

4. State/Country of Formation: FLORIDA / USA

5. Date Organized or Qualified To Do Business in Florida: APRIL 4, 2004

6. FEI Number — ☐ 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: DAVID E. FOSTER JR

Street Address (P.O. Box Number is Not Acceptable): 2727 SHADE TREE DR.

Suite, Apt. #, Etc.: —

City: FLEMING ISLAND State: FL Zip Code: 32003

☑ 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: _____ (REGISTERED AGENT MUST SIGN) Date: 12-16-2009

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	DAVID E. FOSTER JR	2727 SHADE TREE DR	FLEMING ISLAND, FL. 32003

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12/21/09--01079--003 **277.45

REINSTATEMENT 08-09

11. E-mail Address: EMSTC@AOL.COM (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: _____ Date: 12-16-2009 Daytime Phone #: 904-509-4636

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