▲ PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

LIMITED LIABILITY COMPANY REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

FILED
2011 JAN 27 AM 10:03
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

200189512592
01/04/11--01070--014 **238.75

CR2E041 (05/10)

DOCUMENT # L04000094325

1. Limited Liability Company's Name

Digestive Disease Consultants, LLC

2. Principal Office Address - No P.O. Box #	3. Mailing Office Address
2 shircliff Way	
Suite, Apt. #, etc.	Suite, Apt. #, etc.
Suite #435	
City & State	City & State
Jacksonville, Florida	
Zip / Country	Zip / Country
32204 / USA	

4. State/Country of Formation: Florida

5. Date Organized or Qualified To Do Business in Florida: 12/30/04

6. FEI Number: 42-1656000 ☐ 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: Abdi Abbassi

Street Address (P.O Box Number is Not Acceptable): 1105 Ponte Vedra Blvd.

Suite, Apt. #, Etc.:

City: Ponte Vedra Beach | State: FL | Zip Code: 32082

01/28/11--01005--006 **138.75

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: 12/28/10

10. Names and Street Addresses of Managing Members/Managers

Title	Name of Managing Members/Managers	Street Address of Each Managing Member/Manager	City / State / Zip
MGRM	Abdi Abbassi	2 Shircliff Way, #435	Jacksonville, Florida 32204
	REINSTATEMENT-2010 + 2011		

11. E-mail Address: abdiabbassi@gmail.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: 12/28/10 Daytime Phone #: (904) 388-8686

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