

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

LIMITED LIABILITY COMPANY REINSTATEMENT



FLORIDA DEPARTMENT OF STATE Secretary of State DIVISION OF CORPORATIONS

FILED 07 MAY 23 PM 12:36

SECRETARY OF STATE TALLAHASSEE, FLORIDA

DOCUMENT # L05000064465

1. Limited Liability Company's Name WILLIAMSON FAMILY HOME CARE.

2. Principal Office Address - No P.O. Box # 14450 SW 46th CT Ocala, FL, 34473

3. Mailing Office Address 14450 SW 46th CT Ocala, FL, 34473

CR2E041 (1/07)

City & State ocala FL

City & State ocala FL

4. State/Country of Formation

Marion

5. Date Organized or Qualified to Do Business in Florida

6/24/05

6. FE Number

NONE

Applied For

X NOT Applicable

7. CERTIFICATE OF STATUS DESIRED

\$5.00 Additional Fee required for a Certificate of Status

Zip Country Zip Country 34473 MARION 34473 MARION

8. Name and Address of Current Registered Agent

Name OFELIA ZAPATA

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

14450 SW 46th CT

Suite, Apt. #, Etc.

City ocala

State Zip Code FL 34473

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 Ofelia Zapata

REGISTERED AGENT MUST SIGN

Date 5/18/07

10. Names and Street Addresses of Managing Members/Managers

Table with 4 columns: Titles, Name of Managing Members/Managers, Street Address of Each Managing Member/Manager, City/State/Zip. Row 1: MGR OFELIA ZAPATA, 14450 SW 46th CT, ocala FL, 34473

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REINSTATEMENT

06, 07

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

Ofelia Zapata

Date 5/18/07

Daytime Phone # (352) 425-96-93

Typed or printed name of signing Managing Member/Manager