

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

LIMITED LIABILITY
COMPANY
REINSTATEMENT



FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # L06000067530

1. Limited Liability Company's Name

HEALTH STORM MEDICAL LLC

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

565 Whisper Woods Dr

Suite, Apt. #, etc.

City & State

Lakeland FL

Zip

33813

Country

USA

3. Mailing Office Address

Same

Suite, Apt. #, etc.

City & State

Zip

Country

4. State/Country of Formation

FLORIDA

5. Date Organized or Qualified
To Do Business in Florida

7/6/06

6. FEI Number

20-5157149

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

Jun Romo CFO, INC.

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

8706 Maple Lake Pl

Suite, Apt. #, Etc.

City

Tampa

State

FL

Zip Code

33635

☒ 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

4/7/10

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
MEM	DANTON M. SUN	565 WHISPER WOODS DR	LAKELAND FL 33813
		LAKELAND FL 33813	
			500181778785 07/09/10--01041--001 **516.25
			500181778785 06/07/10--01067--008 **138.00

11. E-mail Address:

junromocfo@yahoo.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

4/7/10

Daytime Phone #

8636074908

Typed or printed name of signing Managing Member/Manager