

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

1052

LIMITED LIABILITY COMPANY REINSTATEMENT 2014		FLORIDA DEPARTMENT OF STATE Secretary of State DIVISION OF CORPORATIONS
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FILED

14 OCT 10 AM 8:27

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # **LO7000127937**

1. Limited Liability Company's Name
MEDIISYS MEDICAL, LLC

CR2E041 (1/14)

2. Principal Office Address - No P.O. Box # 13764 Sachs Ave		3. Mailing Office Address 13764 Sachs Ave	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State Orlando, FL		City & State Orlando, FL	
Zip 32827	Country USA	Zip 32827	Country USA

4. State/Country of Formation Florida	
5. Date Organized or Qualified To Do Business in Florida 12/28/2007	
6. FEI Number 26-1648510	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
Corporation Service Company

Street Address (P.O. Box Number is Not Acceptable)
1201 Hays Street

Suite, Apt. #, Etc.

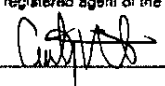
City
Tallahassee

State
FL

Zip Code
32301

500265311325

9. I, being appointed the registered agent of the above named limited liability company, am familiar with and accept the obligations of Chapter 605, F.S.

Signature of Registered Agent:  **Courtney Williams** Date: **10.09.14**

REGISTERED AGENT MUST SIGN **Asst. Vice President**

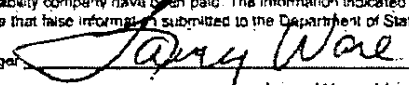
10. Names and Street Addresses of Authorized Representatives/Managers

Titles	Name of Authorized Representative/Managers	Street Address of Each Authorized Representative/Manager	City / State / Zip
AMBR	Larry Ware	13764 Sachs Ave	Orlando, FL 32827

11. E-mail Address: **waremi@mac.com**

(To be used for future annual report notifications)

12. I certify that I am an authorized representative/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 605.0012, 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. I am aware that false information submitted to the Department of State constitutes a third degree felony as provided in s. 817.155, F.S.

Signature of Authorized Representative/Manager:  Date: **10/7/14** Daytime Phone: **813 925 3252**

Typed or printed name of signing Authorized Representative/Manager: **Larry Ware, Member**

K. ASHTON



CORPORATION SERVICE COMPANY

ACCOUNT NO. : I20000000195

REFERENCE : 328053 7623588

AUTHORIZATION :

COST LIMIT : \$298.75

ORDER DATE : October 7, 2014

ORDER TIME : 9:34 AM

ORDER NO. : 328053-010

CUSTOMER NO: 7623588

DOMESTIC FILINGS

NAME: MEDIISYS MEDICAL, LLC

TO AGENCY FILED
SUFFICIENCY OF FILING

2014 OCT -9 AM 11:03

XX REINSTATEMENT

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

 CERTIFIED COPY
XX PLAIN STAMPED COPY
 CERTIFICATE OF GOOD STANDING

CONTACT PERSON: Courtney Williams - Ext# 62935

EXAMINER'S INITIALS _____