PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

LIMITED LIABILITY COMPANY REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

FILED
14 APR 11 AM 10:21
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # L10000116450

1. Limited Liability Company's Name
Gentle Touch Home Health Care LLC

CR2E041 (1/14)

2. Principal Office Address - No P.O. Box #	3. Mailing Office Address
1217 South Military Trail	1217 south Military Trail
Suite, Apt. #, etc.: D	Suite, Apt. #, etc.: D
City & State: west palm beach	City & State: west palm beach
Zip: 33415 Country: palm beach	Zip: 33415 Country: palm beach

4. State/Country of Formation: Florida

5. Date Organized or Qualified To Do Business in Florida: 01/12/2011

6. FEI Number: 27-389-7806 ☐ 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: Herline Lochard

Street Address (P.O. Box Number is Not Acceptable): 4250 sw callicoe st

Suite, Apt. #, Etc.:

City: Port Saint Lucie State: FL Zip Code: 34953

400258935424
04/11/14--01026--017 **138.00

400258935424
04/11/14--01026--016 **243.50

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 _____ Date 4/8/14
REGISTERED AGENT MUST SIGN

10. Names and Street Addresses of Authorized Representatives/Managers

Titles	Name of Authorized Representatives/ Managers	Street Address of Each Authorized Representative/ Manager	City / State / Zip
AR	Nixon Ceme	2903 Poolside Dr	Greenacres 33463

REINSTATEMENT
APR 11 2014
R. HUNT

11. E-mail Address: herinelochard@yahoo.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 4/8/14 Daytime Phone # 561-506-0705

Typed or printed name of signing Authorized Representative/Manager Nixon Ceme