PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

LIMITED LIABILITY COMPANY REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

FILED
2012 MAY 15 AM 11:26
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # L10000126018

CR2E041 (1/11)

1. Limited Liability Company's Name
ANESTHESIA RELATED SERVICES, LLC

2. Principal Office Address - No P.O. Box #	3. Mailing Office Address
12553 EQUINE LANE	SAME
Suite, Apt. #, etc	Suite, Apt #, etc
City & State: WELLINGTON FL	City & State: FL
Zip: 33414 Country: USA	Zip: Country:

4. State/Country of Formation: PALM BEACH
5. Date Organized or Qualified To Do Business in Florida: 12/08/2010
6. FEI Number: [X] 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: GOMEZ JOEL
Street Address (P.O. Box Number is Not Acceptable): 12553 EQUINE LANE
Suite, Apt. #, Etc.:
City: WELLINGTON State: FL Zip Code: 33414

E-mail Address:
05/15/12--01008--001 **377.50
joelinw222@msn.com
(To be used for future annual report notices)

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 _____ Date _____
REGISTERED AGENT MUST SIGN

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
MGR	GOMEZ, JOEL	12553 EQUINE LANE	WELLINGTON, FL 33414
			600235103446 05/15/12--01008--001 **377.50
			JB
			REINSTATEMENT 2011 - 12

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. I am aware that false information submitted in a document to the Department of State constitutes a third degree felony as provided for in s. 817.155, F.S.

Signature of Managing Member/Manager X _____ Date 5/9/12 Daytime Phone # 561-723-6543

Typed or printed name of signing Managing Member/Manager _____