

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

LIMITED LIABILITY
COMPANY
REINSTATEMENT



FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

FILED
SECRETARY OF STATE
DIVISION OF CORPORATIONS

14 MAR 13 PM 2:46

DOCUMENT # L11000107070

1. Limited Liability Company's Name

CALAN PHARMACY & DISCOUNT SERVICE, LLC.

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

1879 W FLAGLER ST

Suite, Apt. #, etc.

3. Mailing Office Address

1879 W FLAGLER ST

Suite, Apt. #, etc.

City & State

MIAMI, FL

City & State

MIAMI FL

Zip

33135

Country

Zip

33135

Country

4. State/Country of Formation

FLORIDA

5. Date Organized or Qualified
To Do Business in Florida

6. FEI Number

453327143

Applied For

Not Applicable

7. CERTIFICATE OF STATUS DESIRED ☐

\$5.00 Additional Fee required
for a Certificate of Status

CR2E041 (1/14)

8. Name and Address of Current Registered Agent

Name

ARTURO A. OMS

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

1879 W FLAGLER ST

Suite, Apt. #, Etc.

City

MIAMI

State

FL

Zip Code

33135

100257812941
03/13/14-01032-005 ***377.50

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

REGISTERED AGENT MUST SIGN

Date

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
P	ARTURO A. OMS	1879 W FLAGLER ST	MIAMI FL 33135

11. E-mail Address. CALAN1879@COMCAST.NET

(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 02/28/2014

Daytime Phone # 305-643-2001

Typed or printed name of signing Authorized Representative/Manager ARTURO A. OMS

RE 3/17/14