PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

LIMITED LIABILITY COMPANY REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

FILED
2018 JUL 23 PM 4:17

CR2E041 (1/14)

DOCUMENT # L12000097768

1. Limited Liability Company's Name
The LASIK Vision Institute Florida, LLC

2. Principal Office Address - No P.O. Box #	3. Mailing Office Address
1555 Palm Beach Lakes Blvd.	1555 Palm Beach Lakes Blvd.
Suite, Apt. #, etc.: Ste 800	Suite, Apt. #, etc.: Ste 800
City & State: West Palm Beach, FL	City & State: West Palm Beach, FL
Zip: 33401 / Country:	Zip: 33401 / Country:

4. State/Country of Formation: FL

5. Date Organized or Qualified To Do Business in Florida: 07/30/12

6. FEI Number: 46-02681872 ☐ 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: NRAI Services Inc.

Street Address (P.O. Box Number is Not Acceptable): 1200 South Pine Island Road

Suite, Apt. #, Etc.:

City: Plantation | State: FL | Zip Code: 33324

700316201427

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: Tammy Tofteroo Tammy Tofteroo Vice President Date: 7/19/2018
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
MGRM	Michael Insler	1555 Palm Beach Lakes Blvd., Ste 800	West Palm Beach, FL 33401

REINSTATEMENT
JUL 23 2018
R. HUNT

11. E-mail Address:
(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: 7/20/18 Daytime Phone #:

Typed or printed name of signing Authorized Representative/Manager:

CT Corp.

3458 Lakeshore Drive, Tallahassee, FL 32312
850-656-4724

Date: 7/23/2018

Acc#I20160000072

Name:	THE LASIK VISION INSTITUTE FLORIDA, LLC
Document #:	L12000097768
Order #:	11081559

Certified Copy of Arts & Amend:	☐			
Plain Copy:	☐			
Certificate of Good Standing:	☐			
	☐			
Apostille/Notarial Certification:	☐		Country of Destination:	
			Number of Certs:	

Filing: (Certified:)

Plain:

COGS:

Availability _____
Document _____
Examiner _____
Updater _____
Verifier _____
W.P. Verifier _____
Ref# _____

Amount: $ 407.50

10 JUL 23 AM 11:22

Thank you!

JUL 23 2018

R. HUNT