
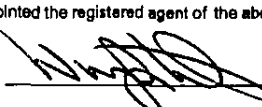
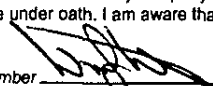


PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM

LIMITED LIABILITY COMPANY REINSTATEMENT		 FLORIDA DEPARTMENT OF STATE Secretary of State DIVISION OF CORPORATIONS		FILED 16 AUG 19 PM 12:41 SECRETARY OF STATE TALLAHASSEE, FLORIDA	
DOCUMENT # L 14000024887				100288926501 08/09/16--01016--004 **1706.25 CR2E041 (1/14)	
1. Limited Liability Company's Name MCLEOD BARBERSHOP, LLC					
2. Principal Office Address - No P.O. Box # 10 South Lake Ave.		3. Mailing Office Address 10 South Lake Ave.		4. State/Country of Formation FL/Union	
Suite, Apt. #, etc.		Suite, Apt. #, etc.		5. Date Organized or Qualified To Do Business in Florida 2-12-2014	
City & State Lake Butler		City & State Lake Butler		6. FEI Number 46-4826822 <input checked="" type="checkbox"/> Applied For <input type="checkbox"/> Not Applicable	
Zip 32054	Country Union	Zip 32054	Country Union	7. CERTIFICATE OF STATUS DESIRED <input checked="" type="checkbox"/> \$5.00 Additional Fee required for a certificate of status	
8. Name and Address of Current Registered Agent					
Name William S. Wilson					
Street Address (P.O. Box Number is Not Acceptable) Suite, 10 South Lake Ave.					
Apt. #, Etc.					
City Lake Butler		State FL	Zip Code 32054	100288926501 08/11/16--01021--022 **971.25	
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 8/8/16	
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	
MGR	William S. Wilson	10 South Lake Ave		Lake Butler, FL 32054	
REINSTATEMENT					
2015-2016					
S. HAWKES					
AUG 9 - A.M.					
EXAMINER					
11. E-mail Address: bill.wilson@msotachinc.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 605, 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 requirement 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 in a document to the Department of State constitutes a third degree felony as provided for in s. 817.155, F.S.					
Signature of authorized representative/member 				Date 8/2/16 Daytime Phone # 386-496-4100	
Typed or printed name of signing authorized representative/member					