

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

LIMITED LIABILITY COMPANY REINSTATEMENT



FLORIDA DEPARTMENT OF STATE Secretary of State DIVISION OF CORPORATIONS

16 JUN -3 PM 3:50

SECRETARY OF STATE TALLAHASSEE, FLORIDA

DOCUMENT # L19 000 144243

1. Limited Liability Company's Name

Epic Maintenance, LLC

800286519198 06/06/16--01003--002 **377.50

CR2E041 (12/13)

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

66 Coleman Road

Suite, Apt. #, etc.

3. Mailing Office Address

66 Coleman Road

Suite, Apt. #, etc.

4. State/Country of Formation

FL

USA

5. Date Organized or Qualified To Do Business in Florida

09/15/2014

6. FEI Number

Applied For Not Applicable

City & State

Crawfordville, FL

City & State

Crawfordville, FL

Zip

32327

Country

USA

Zip

32327

Country

USA

7. CERTIFICATE OF STATUS DESIRED

\$5.00 Additional Fee required for a Certificate of Status

8. Name and Address of Current Registered Agent

Name: Shawn A. Poole

Street Address (P.O. Box Number is Not Acceptable): 66 Coleman Road

Suite, Apt. #, Etc.

City: Crawfordville

State

FL

Zip Code

32327

E-mail Address:

halfast568@me.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 605, F.S.

Signature of Registered Agent: Shawn A. Poole

Date: 06/03/16

REGISTERED AGENT MUST SIGN

10. Names and Addresses of Each Person Authorized to manage the Limited Liability Company

Titles AMBR/MGR	Name of Authorized Person	Street Address of Each Authorized Person	City / State / Zip
owner	Shawn A. Poole	66 Coleman Road	Crawfordville, FL 32327

11. I certify that I am an authorized person 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 requirements of Chapter 605, 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 Person: Shawn A. Poole

Date: 06/03/16 Daytime Phone #: 850-879-841

Typed or printed name of signing Authorized Person

Handwritten signature