

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

**LIMITED LIABILITY  
COMPANY  
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE  
Secretary of State  
DIVISION OF CORPORATIONS

FILED

2020 JAN 27 PM 2:09

DIVISION OF CORPORATIONS  
TALLAHASSEE, FLORIDA

**DOCUMENT #**

1. Limited Liability Company's Name  
Wellington Endoscopy Center, LLC

*11/11/2019 - reject*

~~400333088671~~  
~~01/10/20 - 37022 - 377 - \$100.00~~  
~~400333641844~~  
~~01/27/20 - 01020 - 004 - \$377.50~~  
CR2E041 (1/14)

2. Principal Office Address - No P.O. Box #  
9500 S. Dadeland Boulevard

3. Mailing Office Address

Suite, Apt. #, etc.  
Suite 200

Suite, Apt. #, etc.

City & State  
Miami, FL

City & State

Zip Country  
33156 USA

Zip Country

4. State/Country of Formation  
Florida

5. Date Organized or Qualified  
To Do Business in Florida  
07/01/2016

6. FEI Number  
81-3254698

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  
~~Alejandro Fernandez~~ **Lawrence Freni**  
Street Address (P.O. Box Number is Not Acceptable)  
9500 S. Dadeland Boulevard  
Suite, Apt. #, Etc.  
Suite 200  
City  
Miami

State Zip Code  
FL 33156

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

*Lawrence Freni*

REGISTERED AGENT MUST SIGN

Date *1/9/2020*

**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
CEO	Joseph Garcia	9500 S. Dadeland Boulevard, Suite 200	Miami, FL 33156
CFO	Lawrence Freni	9500 S. Dadeland Boulevard, Suite 200	Miami, FL 33156

11. E-mail Address: *Lfreni@quatrohealth.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 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

*Lawrence Freni*

Date

*1/9/2020*

Daytime Phone #

*305-351-8154*

Typed or printed name of signing Authorized Representative/Manager

*1 MOORE*