PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETINGTHIS FORM

LIMITED LIABILITY COMPANY REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

FILED
2024 DEC -4 PM 3:45

DOCUMENT # L19000303619

1. Limited Liability Company's Name
ELITE MEDICAL WORKSHOPS LLC

CR2E041 (1/14)

2. Principal Office Address - No P.O. Box #	3. Mailing Office Address
7901 4th St N	7901 4th St N
Suite, Apt #, etc: STE 300	Suite, Apt #, etc: STE 300
City & State: St. Petersburg, FL	City & State: St. Petersburg, FL
Zip: 33702 Country: US	Zip: 33702 Country: US

4. State/Country of Formation: Florida

5. Date Organized or Qualified To Do Business in Florida: 12/12/2019

6. FEI Number: 84-4583323 ☐ 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: Registered Agents Inc

Street Address (P.O. Box Number is Not Acceptable) Suite: 7901 4th St N

Apt #, Etc: STE 300

City: St. Petersburg State: FL Zip Code: 33702

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: David Roberts Date: 12/04/2024
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	Manriquez, Juan	7672 NW 5th Street Apt 2F	Plantation FL 33324 US
			● C. LAWRENCE ● DEC - 4 2024

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 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: Juan Manriquez Date: 12/4/2024 Daytime Phone #: _____

Typed or printed name of signing authorized representative/member: Juan Manriquez

Florida Department of State

Division of Corporations

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To:

Division of Corporations
Fax Number : (850)617-6384

From:

Account Name : REGISTERED AGENTS INC.
Account Number : I20090000081
Phone : (307)200-2803
Fax Number : (813)436-5206

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LIMITED LIABILITY REINSTATEMENT
ELITE MEDICAL WORKSHOPS LLC

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