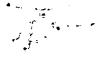
1012

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM. ÁPPLICA ORIDA DEPARTMENT OF STATE Rerine Harris FILED cretary of State SECRETARY OF STATE DIVISION OF CORPORATIONS DOCUMENT # L23098 00 DEC 21 AM 11: 52 1. Corporation Name ELECTRO-MEDICAL ACCESSORIES, INC. Principal Place of Business Mailing Address T7821 N., DALE MABRY HWY STE-200 -STE-200 **TAMPA FL 33614 TAMPA FL 33614** HS HS If above addresses are incorrect in any way, line through incorrect information and enter correction below 3. New Mailing Office Address, If Applicable 7833 N. DAIR MAD T 2. New Principal Office Address, If Applicable 7823 W. Device You About Date Incorporated or Qualified To Do Business in Florida 10/13/1989 Suite, Apt. #, etc. Suite, Apt. #, etc. Applied For 5. FEI Number 59-2972858 City & State City & State Not Applicable TAMPA <u>19447</u> \$8.75 Additional Fee required Country CERTIFICATE OF STATUS DESIRED for a Certificate of Status 7. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at least 3 directors) Name of Officers Street Address of Each Officer and/or Director City / State / Zip and/or Directors Title(s) 14812 N. FLORIDA AVE., #C5 See 6000 - AGENT TAMPA FL D STAFFORD, STEWARD L. 1201-MAGDELENE MANOR DR. 12018 - MANUS Socies Dr. 13918 Shady Shores Dr.) TAMPA FL **VDP EDGERTON, ROY** <del>900003523683</del> -01/04/01--01093--018 \*\*\*\*158.75 \*\*\*\*158.75 9. Name and Address of New Registered Agent 8. Name and Address of Current Registered Agent Name STAFFORD, S. L. CR2E040 Street Address (P.O. Box Number is Not Acceptable) /595/ Suite, Apt. #, Etc. 14812 NORTH FLORIDA AVENUE <del>#6-5</del> TAMPA-FL-33619 -Zip Code 335 7 orporation, am familiar with and accept the obligations of Section 607.0505, F.S 10. I, being appointed the registered seent of 10-18-00 Signature of Registered Agent TERED AGENT MUST SIGN REG 11. I certify that I am an officer or director or the recéiver or trustee empowered to execute this application as provided for in chapter 607 or 617, F.S. I further certify that when filing this reinstatement application, the reason for dissolution has been eliminated, the corporate name satisfies the requirements of section 607.0401 or 617.0401, F.S., that all fees owed by the corporation have been paid and the names of individuals listed on this form do not qualify for an exemption under section 119.07(3)(i), F.S. The information indicated on this application is true and accurate, and my signature shall have the same legal effect as if made under oath. 記切の記

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR





November 9, 2000

Division of Corporations Annual Report / Reinstatement Section P.O. Box 6327 Tallahassee, FL 32314-6327

To whom it may concern:

Our companies have been placed on inactive status by your organization. A customer made this oversight apparent in September of 2000. Our agent and our offices relocated in December of 1999 and therefore the paperwork to renew our status was returned to your office or misplaced in the mail. In light of these circumstances we are requesting a waive of the reinstatement penalty fees for each of our four companies: Analgesic Healthcare, The Analgesic Company of Tampa Bay, Medical Services Diversified / Intermittent Compression Corporation, and Electro-Medical Associates. Please feel free to contact us at 1-813-915-8367 or 1-800-749-1188 ext. 212 with any questions you may have.

Thank you,

Charla Thomas

Director of Operations Analgesic Healthcare, Inc

