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PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETINGTHIS FORM

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SECRETARY OF STATE
TALLAHASSEE, FLORIDA

LIMITED LIABILITY COMPANY REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # M13000006705

1. Limited Liability Company's Name

ASTHMA & ALLERGY PHYSICIANS, LLC

CR2E041 (1/14)

2. Principal Office Address - No P.O. Box #	3. Mailing Office Address
16873 PIERRE CIRCLE	675 PARAMOUNT DR.
Suite, Apt. #, etc.	Suite, Apt. #, etc.
	SUITE 303
City & State	City & State
DELRAY BEACH, FL	RAYNHAM, MA
Zip / Country	Zip / Country
33446 / USA	02767-5416 / USA

4. State/Country of Formation: MASS. / USA

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

6. FEI Number: 13-4244459 ☐ 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: Corporation Service Company

Street Address (P.O. Box Number is Not Acceptable) Suite:
1201 Hays Street

Apt #, Etc.:

City: Tallahassee | State: FL | Zip Code: 32301

200291627632

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: Holly Jones — Holly Jones, Assistant Vice President — Date: 10/19/16

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	MICHAEL LAWRENCE	35 PEARL STREET	BROCKTON, MA 02301

11. E-mail Address: jbachand@aapllc.net
(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: Michael Lawrence MD Date: 10-19-2016 Daytime Phone #: 508-824-4952

Typed or printed name of signing authorized representative/member: MICHAEL LAWRENCE, MD

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SECRETARY OF STATE
TALLAHASSEE, FLORIDA

CORPORATION SERVICE COMPANY
1201 Hays Street
Tallhassee, FL 32301
Phone: 850-558-1500

ACCOUNT NO. : I20000000195

REFERENCE : 345089 8011636

AUTHORIZATION : Lynn Coleman

COST LIMIT : $ 238.75

ORDER DATE : October 25, 2016

ORDER TIME : 3:01 PM

ORDER NO. : 345089-005

CUSTOMER NO: 8011636

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REINSTATEMENT

NAME: ASTHMA & ALLERGY PHYSICIANS, LLC

XX REINSTATEMENT

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

_____ CERTIFIED COPY
XX PLAIN STAMPED COPY
_____ CERTIFICATE OF GOOD STANDING

CONTACT PERSON: Melissa Zender

EXAMINER'S INITIALS _____