PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

LIMITED LIABILITY COMPANY REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

FILED
SECRETARY OF STATE
DIVISION OF CORPORATIONS
16 DEC -2 PM 2:17

DOCUMENT # M15000096047

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CR2E041 (1/14)

1. Limited Liability Company's Name
LETCO MEDICAL, LLC

2. Principal Office Address - No P.O. Box #	3. Mailing Office Address
1316 COMMERCE DR NW	
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State: DECATUR, AL	City & State
Zip: 35601 / Country	Zip / Country

4. State/Country of Formation: Delaware

5. Date Organized or Qualified To Do Business in Florida: 12/02/2015

6. FEI Number: 36-4812242 ☐ 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: C T CORPORATION SYSTEM

Street Address (P.O. Box Number is Not Acceptable): 1200 SOUTH PINE ISLAND ROAD

Suite, Apt. #, Etc.:

City: PLANTATION | State: FL | Zip Code: 33324

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: Danny Verdecchia Assistant Secretary Date: 12/1/16
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
Pres & C	Todd Way	460 E. Swedesford Road, Suite 2040	Wayne, PA 19087

REINSTATEMENT 2016

11. E-mail Address: NAnderson@LetcoMedical.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: Todd A. Way Date: 11/30/16 Daytime Phone #: 734-843-4600

Typed or printed name of signing Authorized Representative/Manager: Todd A. Way Member

DEC -2 2016

M. WILLIAMS

CT CORPORATE

3458 Lakeshore Drive, Tallahassee, FL 32312
850-656-4724

Date: 12/2/16

ACCT: I20160000072

Tina

Name:	Letco Medical, LLC
Document #:	M15000009647
Order #:	1024251

Certified Copy of Arts & Amend:				
Plain Copy:	X			
Certificate of Good Standing:				
Apostille/Notarial Certification:			Country of Destination:	
			Number of Certs:	

Filing:

Certified:

(Plain:)

COGS:

Availability _____
Document _____
Examiner _____
Updater _____
Verifier _____
W.P. Verifier _____
Ref# _____

Amount: $ 538.75

Thank you!