2007 NOT-FOR-PROFIT CORPORATION REINSTATEMENT

Stock Stoc	1. Entity Nam EAST FL	MENT # N0300000 PHYSICIAN ALLIAN			FILED 07 00T 25 PM 2: 55		
Suite. Apt. #. etc. Suite. Apt. #. etc.	4101 S HOS STE. 1	PITAL DR.	4101 S HOSPITAL DI STE. 1	4101 S HOSPITAL DR. STE. 1			
City & State City & State City & State City & State Country Zip Country Zip Country Zip Country Zip Country S. Certificate of Status Desired \$8.75 Additional Fee Required \$8	2. Principal Place of Business - No P.O. Box # 3.		3. Mailing Address	3. Mailing Address			
Zip Country Zip Country Zip Country 55-0827870 Not Applied - C. Narice and Address of Current Registered Agent 7. Name and Address of Name Registered Agent 8. Name STE 500, 280 S AUSTRALIAN AVE W PALM BEACH, FL 33401 Street Address (P.O. Box Number is Not Acceptable) - City FL Zip Code 8. The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Ronda. I am familiar with, and acretic headbligations of registered agent	Suite, Apt. #, etc.		Suite, Apt. #, etc.		092461181A	EM GR2E099 (1/07) 6	
Country Cou	City & State		City & State			Applied For Not Applicable	
FARRELL, JAMES A STE 500, 250 S AUSTRALIAN AVE W PALM BEACH, FL 33401 6. The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. I am familiar with, and act the obligations of registered agent. SIGNATURE Signature forece or imperience agent and line if applicable (NOTE, Registered Agent alignature required when nemotating) DATE	Zip	Country	Zip	Country	5. Certificate of Status Desir	ed \$8.75 Additional	
STEE 500, 250 S AUSTRALIAN AVE W PALM BEACH, FL 33401 Street Address (P.O. Box Number is Not Acceptable) City FL Zip Code 6. The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. I am familiar with, and act the obligations of registered agent. SIGNATURE Signature Signatur		6. Name and Address of Current	Registered Agent	Name	7 Name and Address of New Registered Agent		
S. The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. I am familiar with, and act the obligations of registered agent. SIGNATURE Signature, noted or purised rame of registered agent and tide if applicable (MOTE: Registered Agent algorithm required when reinstating) DATE	STE 500, 2	250 S AUSTRALIAN AVE		Street Address	Street Address (P.O. Box Number is Not Acceptable)		
THE ODIGISIONS OF registered agent. SIGNATURE FILE NOWIT FEE IS \$61.25 After January 1, 2008, Fee will be \$122.50 In accordance with s. 607.193(2)(b), F.S., the corporation did not receive the prior notice. Make check payable to Florida Department of State 10. OFFICERS AND DIRECTORS ITILE D OFFICERS AND DIRECTORS ITILE MAME KATZMAN, HOWARD M.D. STREET ADDRESS CITY ST-2P PLANTATION, FL 33317 ITILE D OBelele STREET ADDRESS CITY-S1-2P LANTATION, FL 33317 ITILE D OBELET ADDRESS CITY-S1-2P LANTATION, FL 33317 Delete ITILE D OBELET ADDRESS CITY-S1-2P LANTATION, FL 33317 Delete ITILE D OBELET ADDRESS CITY-S1-2P LANTATION, FL 33317 Delete ITILE D OBELET ADDRESS CITY-S1-2P TITLE TITLE C OBELET ADDRESS CITY-S1-2P TITLE TITLE C OBELET ADDRESS CITY-S1-2P TITLE C OBELET ADDRESS CITY-S1-2P TITLE TITLE C OBELET ADD				'	' FL ""		
Signature, board or crimited name of regotivered agent and time if applicable INTER-Registanced Agent alignature required when reinstasticing) DATE	8. The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. I am familiar with, and accept the obligations of registered agent.						
After January 1, 2008, Fee will be \$122.50 Total Delete	SIGNATURE .		t and title if applicable (Ni	OTE: Registered Agent algosture requ	uired when reinstating)	DATE	
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12. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Chapter 119. Florida Statutes. I further certify that the information does not supplemental report is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am an officer or direct of the corporation or the receiver or trustee/empowered to execute this report as required by Chapter 617, Florida Statutes, and that my name appears in Block 10 or	NAME STREET ADDRESS CITY-ST-ZIP TITLE NAME STREET ADDRESS CITY-ST-ZIP TITLE NAME STREET ADDRESS CITY-ST-ZIP TITLE NAME STREET ADDRESS STREET ADDRESS	BORNIA, MANUEL M.D. 4101 S HOSPITAL DR., STE. 1	☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP TITLE NAME STREET ADDRESS	0'NU/2GD	☐ Change ☐ Addition ☐ Change ☐ Addition	
SIGNATURE: SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Days Phone &	NAME STREET ADDRESS CITY-ST-ZIP TITLE NAME STREET ADDRESS CITY-ST-ZIP TITLE NAME STREET ADDRESS CITY-ST-ZIP TITLE NAME STREET ADDRESS CITY-ST-ZIP	BORNIA, MANUEL M.D. 4101 S HOSPITAL DR., STE. 1 PLANTATION, FL 33317	☐ Delete ☐ Delete ☐ Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	ed in Chapter 119. Florida Statu same legal effect as if made un 7, Florida Statules; and that my	Change Addition Change Addition Change Addition	