PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION •∽ FÖR REINSTATEMENT



FLORIDA DEPARTMENT OF STATE Katherine Harris

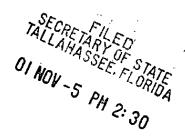
Secretary of State DIVISION OF CORPORATIONS

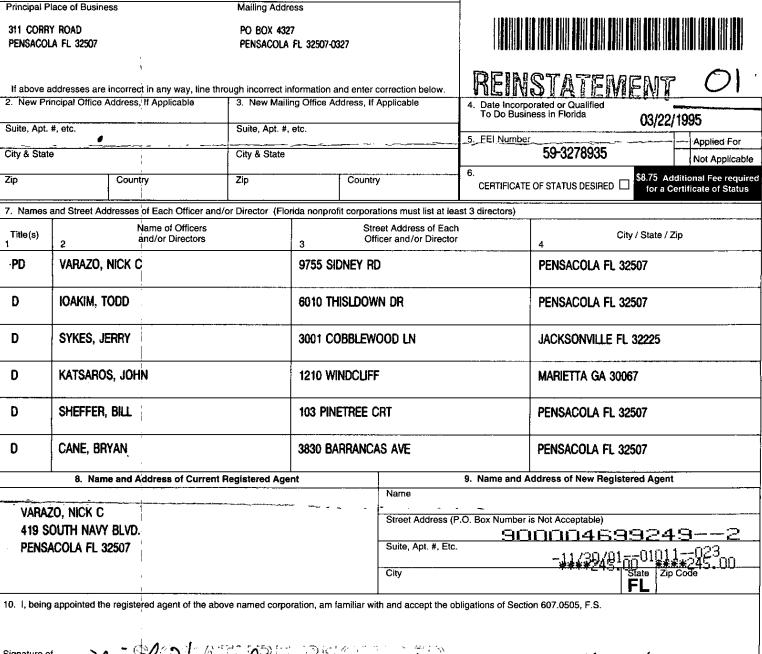
DOCUMENT # N95000001383

1. Corporation Name

DISABLED VETERANS EMERGENCY AID MISSION, INC.

Principal Place of Business





11. I certify that I am an officer or director or the receiver 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.

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Daytime Phone #