PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION **FOR** REINSTATEMENT



FLORIDA DEPARTMENT OF STATE Jim Smith

Secretary of State DIVISION OF CORPORATIONS

DOCUMENT # PC	0000005828
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1. Corporation Name

NATIONAL MEDICINE CENTER, INC.

Principal Place of Business

Mailing Address

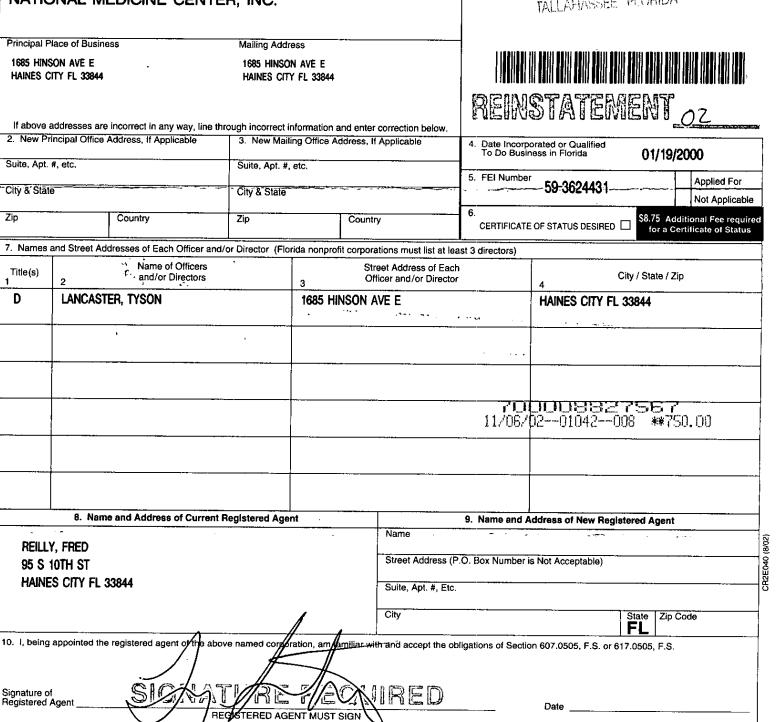
1685 HINSON AVE E HAINES CITY FL 33844

Zip

1685 HINSON AVE E HAINES CITY FL 33844 FILED

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SECRETARY OF STATE TALLAHASSEE FLORIDA



If above addresses are incorrect in any way, line through incorrect information and enter correction below.

2. New Principal Office Address, If Applicable 3. New Mailing Office Address, If Applicable Suite, Apt. #, etc. Suite, Apt. #, etc. City & State City & State

Country

Country

7. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at least 3 directors) Name of Officers Title(s) c. and/or Directors

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		11/06/	000088 0201042-

8. Name and Address of Current Registered Agent

REILLY, FRED 95 S 10TH ST HAINES CITY FL 33844

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 filling 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 effect as if made under oath.

Signature of Registered Agent

AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR