CAPITAL CONNECTION 850 222 1222 04/11 '02 11:13 NO.859 01/02

P5 1 02

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

CORPORATION REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Katherine Harris
Secretary of State
DIVISION OF CORPORATIONS

FILED
04 JUN -3 PM 2:53
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P00000007917

1. Corporation Name: Pro- Care Medical Supplies, Inc.
8045 NW 36 Street #565.
Miami, Florida 33166.

000037798730
06/09/04--01029--032 **450.00

REINSTATEMENT 02-04

2. Principal Office Address	3. Mailing Office Address
8045 NW 36 St.	8045 NW 36 St.
Suite, Apt. #, etc. #565	Suite, Apt. #, etc. #565
City & State Miami, Florida.	City & State Miami, Florida
Zip 33166 Country USA	Zip 33166 Country USA

4. Date Incorporated or Qualified To Do Business In Florida: 01-25-00

5. FEI Number: 65-0974677 ☐ Applied For ☐ Not Applicable

6. CERTIFICATE OF STATUS DESIRED ☐ $8.75 Additional Fee required for a Certificate of Status

7. Name and Address of Current Registered Agent

Name: Luis Gonzalez / ~~Pro-Care Medical Supplies, Inc~~
Street Address (P.O. Box Number Is Not Acceptable): 8045 NW 36 Street
Suite, Apt. #, Etc.: #565
City: Miami State: FL Zip Code: 33166

8. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of section 607.0505 or 617.0503, F.S.

Signature of Registered Agent X _____ Date June 02, 2004
REGISTERED AGENT MUST SIGN

9. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at least 3 directors)

Titles	Name of Officers and/or Directors	Street Address of Each Officer and/or Director	City / State / Zip
P, VP, T, S.	Luis Gonzalez.	8045 NW 36 St #565 Miami, Florida 33166	miami, Florida 33166.

10. 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.

SIGNATURE: X _____ 06/02/04 305-468-9444
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

Tla.

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Pro-Care Medical Supplies, Inc.
8045 NW 36 Street # 565
Miami, Florida 33166
(305) 468 - 9444

June 02, 2004

Via Airborne

Capital Connection
Attn Stacey
417 East Virginia Street
Suite # 1
Tallahassee, Florida 32301

Re: Reinstatement of Corporation of Pro-Care Medical Supplies, Inc.

To Whom It May Concern:

It has come to our attention that our annual report has never been filed as a result our corporation has been dissolved. Enclosed please find a corporation reinstatement form along with a check for $ 450.00. **Please note we have never received the annual renewal forms from your offices.** (2002 - 2004)

Sincerely,

Luis Gonzalez