


2008 FOR PROFIT CORPORATION REINSTATEMENT

DOCUMENT # P00000025370		
1. Entity Name INTERNATIONAL MEDICAL CARE NETWORK, INC.		

FILED
08 NOV 10 PM 2:59
CLERK OF STATE
TALLAHASSEE, FLORIDA

Principal Place of Business 2525 HARBOR BLVD. 312 PORT CHARLOTTE, FL 33952	Mailing Address 2525 HARBOR BLVD. 312 PORT CHARLOTTE, FL 33952
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2. Principal Place of Business - No P.O. Box #		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country

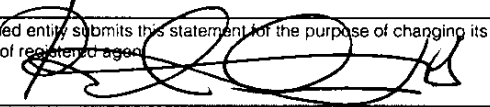


1102008 (REINSTATEMENT) 11/10/08 (1/07)	
4. FEI Number 65-1014322	Applied For Not Applicable
5. Certificate of Status Desired <input type="checkbox"/> \$8.75 Additional Fee Required	

6. Name and Address of Current Registered Agent GIL, RAMON A M.D. 2525 HARBOR BOULEVARD SUITE 312 PORT CHARLOTTE, FL 33952	
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7. Name and Address of New Registered Agent	
Name	
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 Florida. I am familiar with, and accept the obligations of registered agent.

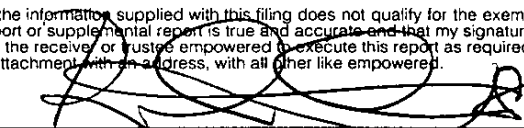
SIGNATURE:  DATE: 11/10/08

Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)

FILE NOW!!! FEE IS \$150.00 After January 1, 2009, Fee will be \$300.00	In accordance with s. 607.193(2)(b), F.S., the corporation did not receive the prior notice.
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10. OFFICERS AND DIRECTORS		11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D GIL, RAMON A M.D. 2525 HARBOR BOULEVARD #312 PORT CHARLOTTE, FL 33952 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	D THIMM, SALLY 5865 HARRISON RD VENICE, FL 34293 <input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	800137780188 <input type="checkbox"/> Change <input type="checkbox"/> Addition 11/10/08--01020--014 **150.00
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition

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 indicated on this report or 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 director of the corporation or the receiver or trustee empowered to execute this report as required by Chapter 607, Florida Statutes; and that my name appears in Block 10 or Block 11 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE:  DATE: 11/10/08 Daytime Phone #: 941-748-4987

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR