PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

FILED
03 NOV 24 AM 11:57
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

CORPORATION REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # P00000067562

REINSTATEMENT 03

1. Corporation Name
ALLIED MEDICAL & REHAB CENTER, INC.

2. Principal Office Address	3. Mailing Office Address
407 Lincoln Road	407 Lincoln Road
Suite, Apt. #, etc.: 2A	Suite, Apt. #, etc.: 2A
City & State: Miami, Florida	City & State: Miami, Florida
Zip: 33139 Country: USA	Zip: 33139 Country: USA

4. Date Incorporated or Qualified To Do Business in Florida: 07/12/2000

5. FEI Number: 65-1022138 ☐ 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: Igor Barsky

Street Address (P.O. Box Number is Not Acceptable): 407 Lincoln Road

300024979538
11/24/03--01084--004 **50.00

Suite, Apt. #, Etc.: 2A

City: Miami State: FL Zip Code: 33139

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: _____ Date: 11/20/03

REGISTERED AGENT MUST SIGN

CR2E081 (10/02)

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	IGOR BARSKY	407 LINCOLN ROAD, STE 2A	MIAMI, FLORIDA, 33139

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: _____ 11/20/03 609-468-1505

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

November 19, 2003

Allied Medical & Rehab Center, Inc.
C/o Douglas D. Stratton
407 Lincoln Road, Ste 2A
Miami, FL 33139

Department of State
Division of Corporations
P.O. Box 6327
Tallahassee, FL 32314

Dear Sir or Madam:

Enclosed please find our reinstatement application and a check for $150.00. We are hereby requesting that the penalty for failure to file our annual report be waived. Our company's mailing address changed to 407 Lincoln Road, Suite 2A, Miami, Florida 33139 and the post office was duly notified. Unfortunately the post office did not forward our mail to the correct address and therefore, we were unable to file our annual report.

Thank you very much for your understanding and co-operation in this matter.

Respectfully yours,

Igor Barsky