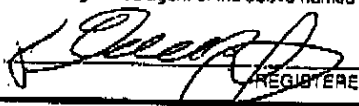
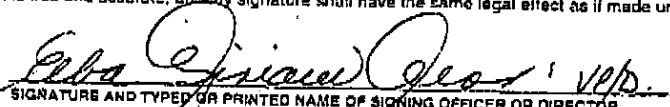


HO2000228421 2 PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

CORPORATION REINSTATEMENT		 FLORIDA DEPARTMENT OF STATE Katherine Harris Secretary of State DIVISION OF CORPORATIONS		FILED 02 NOV 20 AM 9:45 SECRETARY OF STATE TALLAHASSEE, FLORIDA	
DOCUMENT #		P00000078930			
1. Corporation Name DOCTORS HEALTH GROUP N.W. INC.					
2. Principal Office Address 2435 NW 7th street Suite, Apt. #, etc.		3. Mailing Office Address SAME Suite, Apt. #, etc.		REINSTATEMENT 02	
City & State Miami, Florida		City & State			
Zip 33125	Country USA	Zip	Country		
4. Date Incorporated or Qualified To Do Business in Florida 8-14-2000					
5. FEI Number 650485918		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 EDDIE MOR					
Street Address (P.O. Box Number is Not Acceptable) 2435 NW 7th Street					
Suite, Apt. #, Etc.					
City Miami					
State FL					
Zip Code 33125					
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  REGISTERED AGENT MUST SIGN Date 11-19-02					
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/D	EDDIE, MOR	2435 NW 7th Street		Miami, FL 33125.	
V/D	ELBA M. MOR	1717 N. Bayshore Dr,		#2751, Miami, FL 33134.	
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:  SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR 11-19-2002 Date Daytime Phone 					

Florida Department of State
Division of Corporations
Public Access System

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((H02000228421 2)))

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To:
Division of Corporations
Fax Number : (850) 205-0384

From:
Account Name : FAS-T CORP. AGENTS, INC.
Account Number : 071001002335
Phone : (305) 599-0839
Fax Number : (305) 716-0346

CORPORATION REINSTATEMENT

DOCTORS HEALTH GROUP N.W. INC.

Certificate of Status	0
Certified Copy	0
Page Count	01
Estimated Charge	\$750.00