

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

**CORPORATION  
REINSTATEMENT**



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

FILED

02 APR -3 AM 11:58

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

DOCUMENT # P00000081751

**1. Corporation Name**

Pro-Med Care, Inc

**2. Principal Office Address**

7801 Coral Way

Suite, Apt. #, etc.

Suite 105

City & State

Miami Florida

Zip

33155

Country

Miami-Dade

**3. Mailing Office Address**

Same

Suite, Apt. #, etc.

City & State

Zip

Country

**4. Date Incorporated or Qualified  
To Do Business in Florida**

1/2001

**5. FEI Number**

65-1045192

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

Alamy S. Dominguez

Street Address (P.O. Box Number is Not Acceptable)

7801 Coral Way

Suite, Apt. #, Etc.

Suite 105

City

Miami

State

FL

Zip Code

33155

**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

*[Signature]*

REGISTERED AGENT MUST SIGN

Date 4-2-02

**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
President	Alamy S. Dominguez	7801 Coral Way #105	Miami, Fl. 33155

**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]*

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

4-2-02 (305) 265-4040

Date

Daytime Phone #



272

4/1/02

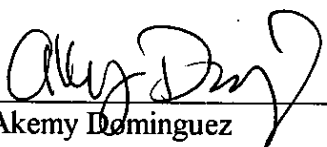
Florida Department of State  
Division of Corporation  
P.O. Box 6327  
Tallahassee, FL 32314

To whom it may concern,

The application for the renewal of this corporation Pro Med Care Inc. was sent to the office address that was on file which is 7815 SW 24 St. Suite 111 Miami FL 33155. This address was a temporary location for this corporation and we never received our renewal notice, because we moved locations shortly after. Our new permanent address for this office is 7801 Coral Way Suite 105 Miami FL 33155.

At this time we are sending the payment for \$300.00 to reinstate Pro Med Care Inc's corporation status up to date. We thank you in advance for your understanding due to the circumstances causing this confusion. If you may need any further information please feel free to contact us at (305) 265-4040.

I Thank you again  
Sincerely,

  
Akemy Dominguez  
President