

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

CORPORATION REINSTATEMENT		 FLORIDA DEPARTMENT OF STATE Katherine Harris Secretary of State DIVISION OF CORPORATIONS	
DOCUMENT # P00000097682 1. Corporation Name HEALTHQUEST MEDICAL PARTNERSHIP, INC.			
2. Principal Office Address 10000 S.W. 56TH STREET Suite, Apt. #, etc. SUITE # 3 & 4 City & State MIAMI, FL Zip 33165		3. Mailing Office Address SAME Suite, Apt. #, etc. _____ City & State _____ Zip _____	
Country U.S.A.		Country _____	

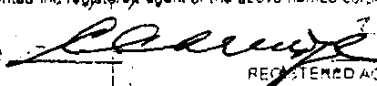
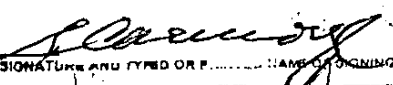
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SECRETARY OF STATE
TALLAHASSEE, FLORIDA

4. Date Incorporated or Qualified To Do Business in Florida		10/17/2000
5. FEI Number	65-1068490	Applied For ☐ Not Applicable
6. CERTIFICATE OF STATUS DESIRED ☐		\$0.75 Additional Fee required for a Certificate of Status

7. Name and Address of Current Registered Agent	
Name CONCEPCION CARMOUZE	
Street Address (R.O. Box Number is Not Acceptable) 6545 S.W. 95TH AVENUE	
Suite, Apt. #, Etc. _____	
City MIAMI	State FL
Zip Code 33173	Zip Code 33173

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 2/15/02	
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
D	CONCEPCION CARMOUZE	6545 S.W. 95TH AVENUE	MIAMI, FL 33173
P	CONCEPCION CARMOUZE	6545 S.W. 95TH AVENUE	MIAMI, FL 33173
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: 		Date 2/15/02 (305) 989-3850	
SIGNATURE AND TYPED OR PRINTED NAME OF REGISTERING OFFICER OR DIRECTOR		Date Daytime Phone #	

CR25681 (9/00)



Healthquest Medical Partnership

10000 SW 56 St., Suite # 3, Miami, FL 33165
Ph: (305) 595-6961 Fax: (305) 595-6963

Febreaury 25, 2002

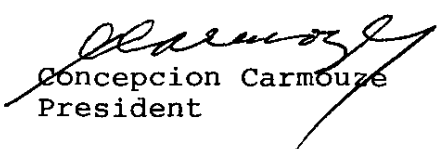
To Whom it may Concern:

I am requesting a waiver of the penalty fees assessed to my Corporation. I was never in receipt of the 2001 Form as the address in your records was incorrect.

I am enclosing a completed reinstatement form along with a check for \$300.00 which cover the balance outstanding on my account for 2001 and 2002 fillings.

If you have any question, please feel free to contact me at 305-282 9458.

Sincerely


Concepcion Carmouze
President

Document # P00000097692