PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

CORPORATION REINSTATEMENT

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

FILED
02 FEB 27 PM 2:12
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P00000097682

1. Corporation Name
HEALTHQUEST MEDICAL PARTNERSHIP, LLC

2. Principal Office Address	3. Mailing Office Address
10000 S.W. 56TH STREET	SAME
Suite, Apt. #, etc. SUITE # 3 & 4	Suite, Apt. #, etc.
City & State MIAMI, FL	City & State
Zip 33165 / Country U.S.A.	Zip / Country

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 ☐ — $8.75 Additional Fee required for a Certificate of Status

7. Name and Address of Current Registered Agent

Name: CONCEPCION CARMOUZE

Street Address (P.O. Box Number is Not Acceptable): 6545 S.W. 95TH AVENUE

Suite, Apt. #, Etc.:

City: MIAMI — State: FL — Zip Code: 33173

900005183543--5
-04/02/02--01058--007
****300.00 ****300.00

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

CR2E081 (9/01)

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: _____ 2/15/02 (305)989-3850
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

Val 2

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

Febreauy 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 # P00000097682