PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Jim Smith
Secretary of State
DIVISION OF CORPORATIONS

FILED
02 NOV 15 PM 4:01
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P01000040930

1. Corporation Name

BETTER MEDICAL CARE, INC.

Principal Place of Business	Mailing Address
8415 AUBURN CIRCLE ORLANDO FL 32817	8415 AUBURN CIRCLE ORLANDO FL 32817

If above addresses are incorrect in any way, line through incorrect information and enter correction below.

2. New Principal Office Address, If Applicable

Suite, Apt. #, etc.

City & State

Zip | Country

3. New Mailing Office Address, If Applicable

852-31 SAXON BLVD

Suite, Apt. #, etc.

City & State: Orange City

Zip: FL 32763 | Country: USA

4. Date Incorporated or Qualified To Do Business in Florida: 04/23/2001

5. FEI Number: 59-3712155. ☐ Applied For ☐ Not Applicable

6. CERTIFICATE OF STATUS DESIRED ☑ $8.75 Additional Fee required for a Certificate of Status

7. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at least 3 directors)

1 Title(s)	2 Name of Officers and/or Directors	3 Street Address of Each Officer and/or Director	4 City / State / Zip
P	YOUSSEF, SHENOUDA	8415 AUBURN CIRCLE	ORLANDO FL 32817

200009024012
11/15/02--01060--019 **158.75

8. Name and Address of Current Registered Agent

YOUSSEF, SHENOUDA
8415 AUBURN CIRCLE
ORLANDO FL 32817

9. Name and Address of New Registered Agent

Name

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

Suite, Apt. #, Etc.

City | State: FL | Zip Code

CR2E040 (8/02)

10. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of Section 607.0505, F.S. or 617.0505, F.S.

Signature of Registered Agent: SIGNATURE REQUIRED
REGISTERED AGENT MUST SIGN

Date: 11/12/02

11. 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 REQUIRED
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date: 11/12/02

Daytime Phone #

Better Medical Care, Inc.

852-31 Saxon Blvd
Orange City, FL 32763
(386) 774-6800

Tuesday, November 12, 2002

Division of Corporations
Florida Department of State
Division of Licensing
Post Office Box 6327
Tallahassee, Florida 32314

Dear Sir/ Madam:

Please be advised that we didn't receive the renewal notice for Better Medical Care, Inc. Please accept this letter as an apology and waive the late fee for the corporate renewal.

Enclosed please find a check for $158.75 for the renewal fee.

Thank you in advance for your help in this matter.

Please contact this office at 386-774-6800 to discuss this matter further.

Sincerely yours,

Shenouda Youssef

Enclosure