

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

**8415 AUBURN CIRCLE  
ORLANDO FL 32817**

Mailing Address

**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:

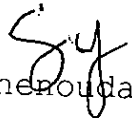
Please be advised that we didn't receive the renewal notice for Better Medical Care, Inc.  
Please accept this letter as an apology and waive the late fee for the corporate renewal.

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