PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT 02 WSO

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

FILED
02 OCT 24 PM 2:52
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P01000110471

1. Corporation Name

FLORIDA OCCUPATIONAL HEALTHCARE, INC.

Principal Place of Business	Mailing Address
9400 SW 106TH AVENUE MIAMI FL 33176	9400 SW 106TH AVENUE MIAMI FL 33176

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

2. New Principal Office Address, If Applicable	3. New Mailing Office Address, If Applicable
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State	City & State
Zip / Country	Zip / Country

4. Date Incorporated or Qualified To Do Business in Florida: 11/19/2001

5. FEI Number: 65 0848073 ☐ 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
PVST	PEREDA, ALEX	9400 SW 106TH AVENUE	MIAMI FL 33176
D	PEREDA, ALEX	9400 SW 106TH AVENUE	MIAMI FL 33176

300008577863
10/24/02--01099--018 **150.00

8. Name and Address of Current Registered Agent

PEREDA, ALEX
9400 SW 106TH AVENUE
MIAMI FL 33176

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: 10/21/02

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 Alejandro Pereda 10/21/02
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

FLORIDA OCCUPATIONAL
Healthcare

"Your Healthcare Provider"

Secretary of State
Division of Corporation
P.O. Box 6327
Tallahasse, FL., 32314
ATTN: Reinstatement Section

To Whom It May Concern:
Please be advised that I have not received my first nor my second notice for the Annual Report for the year 2002. Please accept my check for the amount of 150^{00} for the renewal of the year 2002.

Florida Occupational Healthcare
9400 SW 106 Ave.
Miami, FL, 33176

9135 S.W. 87 Avenue • Miami, Florida 33176 • Tel: (305) 274-3311 • Fax: (305) 274-1411