

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM

APPROVED
AND
FILED

112

**CORPORATION
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

05 JUN 14 AM 10:53

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # **P02000029233**

1. Corporation Name
**COMPLETE HEALTH AND
REHABILITATION CENTER INC.**

2. Principal Office Address
3061 W. FLAGLER ST

Suite, Apt. #, etc.

City & State
Miami, FL

Zip Country
33135 USA

3. Mailing Office Address
9618 FT. BLEAU BLVD

Suite, Apt. #, etc.

City & State
Miami FL 33172

Zip Country
33172 USA

REINSTATEMENT 03-05

4. Date Incorporated or Qualified
To Do Business in Florida **03-18-2002**

5. FEI Number **030417714**

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
Carlos M. Martinez

Street Address (P.O. Box Number is Not Acceptable)
9618 FT. BLEAU BLVD.

Suite, Apt. #, Etc.
#395

City
Miami

100056398841

06/21/05--01059--001 **410.00

450.00

0.00

State Zip Code
FL 33172

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 **Carlos M Martinez**

Date **6/13/05**

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
PD	CARLOS M MARTINEZ	9618 FT. BLEAU BLVD #395	Miami, FL 33172

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)(l), 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:

Carlos M Martinez **6/13/05** **(305) 910-6864**

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

CR2001 (01/05)

2/2

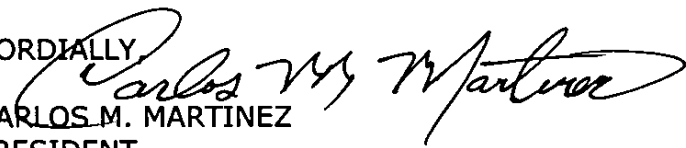
**COMPLETE HEALTH AND REHABILITATION
CENTER INC.**

TO: DIV OF CORPORATION

AS PER OUR PHONE CONVERSATION I AM SENDING TO YOU THIS LETTER OF EXPLANATION AND THE UBR FORM ALONG WITH A CHECK TO PROPERLY UPDATE CORPORATION I FURTHER STATE THAT I DID NOT RECEIVE THE NOTICE FOR 2003 UBR FIRST NOR SECOND NOTICE. I WOULD LIKE TO RESOLVE THIS ISSUE, PLEASE TAKE THIS LETTER AS AN EXCUSE TO PUT THIS CORPORATION IN ITS CURRENT STATUS AND WAIVE ANY LATE FEES.

I HAVE A NEW MAILING ADDRESS PLEASE MAKE A NOTE OF IT.

CORDIALLY


CARLOS M. MARTINEZ
PRESIDENT