

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION
FOR
REINSTATEMENT



FLORIDA DEPARTMENT OF STATE

Glenda E. Hood
Secretary of State

DIVISION OF CORPORATIONS

DOCUMENT # P02000060300

1. Corporation Name

A+ MEDICAL SUPPLY, INC.

Principal Place of Business

7750 W 24 AVE BAY-18
HIALEAH FL 33016

Mailing Address

7750 W 24 AVE BAY-18
HIALEAH FL 33016

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

Suite, Apt. #, etc.

City & State

Zip

Country

4. Date Incorporated or Qualified
To Do Business in Florida

05/31/2002

5. FEI Number

75-3062448

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)

Title(s) 1	Name of Officers and/or Directors 2	Street Address of Each Officer and/or Director 3	City / State / Zip 4
P	LLAURADO, MELISA	7750 W 24 AVE BAY-18	HIALEAH FL 33016

200024388422
11/03/03--01100--007 **150.00

8. Name and Address of Current Registered Agent

LLAURADO, MELISA
7750 W 24 AVE BAY-18
HIALEAH FL 33016

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

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]

REGISTERED AGENT MUST SIGN

Date 10-22-03

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]
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

10-22-03

Date

(305) 823-8002
Daytime Phone #

CR2E040 (7/03)

A+ Medical Supplies, Inc.

7750 West 24 Avenue, Bay 18

Kissimmee, Florida 33016

October 23, 2003

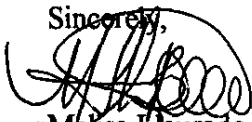
Department of State
Division of Corporations
P.O. Box 6327
Tallahassee, Florida 32314

To whom it may concern:

Following you will find my reinstatement application along with a one hundred fifty dollar, (\$150.00), check. I am hereby requesting for the late fee to be waived to due the fact that I did not receive a prior notice. Please pardon my ignorance; if I had known that this was required, I would have followed up even though the notice was not received.

If you have any questions, please feel free to contact me at (305) 823-8002. I thank you in advance for your concern with this matter.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa Laurado', enclosed within a circular scribble.

Melissa Laurado
President