

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 # P02000102076

1. Corporation Name

S.W. MEDICAL CENTER, INC.

Principal Place of Business

Mailing Address

~~874 SW 8 ST~~  
MIAMI FL 33130

~~874 SW 8 ST~~  
MIAMI FL 33130

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.  
861 SW. 8 ST.

Suite, Apt. #, etc.  
861 SW. 8 ST.

City & State  
Miami, FL.

City & State  
Miami, FL.

Zip Country  
33130 USA.

Zip Country  
33130 USA.

4. Date Incorporated or Qualified  
To Do Business in Florida

09/20/2002

5. FEI Number

383660800

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
D	MEDINA, DIEGO	874 SW 8 ST	MIAMI FL 33130
D	ODOARDO, DENIO	874 SW 8 ST	MIAMI FL 33130
D	COLAS, SUSANA	874 SW 8 ST	MIAMI FL 33130

800023751968

10/13/03--01073--021 \*\*150.00

8. Name and Address of Current Registered Agent

9. Name and Address of New Registered Agent

COLAS, SUSANA  
520 BRICKELL KEY DR  
MIAMI FL 33131

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

REGISTERED AGENT MUST SIGN

Date 10-09-03

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 AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

10-09-03

(305)  
858-3433

CR2E040 (7/03)

October 9, 2003

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

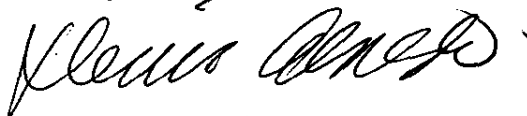
Re: S.W. Medical Center, Inc.  
874 SW 8 Street  
Miami, FL 33130  
Document# P02000102076

We are writing because we did not receive the prior UBR notices. We have received this notice of Dissolution or Revocation, since we did not receive these notices and therefore did not mail you the required fees.

Please waive the reinstatement Fees.

We are enclosing our Application for Reinstatement along with a check for \$150.00.

Sincerely Yours,

A handwritten signature in black ink, appearing to read "Denio Odoardo", written over a horizontal line.

Denio Odoardo  
Director