

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

**CORPORATION  
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE  
Secretary of State  
DIVISION OF CORPORATIONS

**FILED**

2007 NOV 20 AM 10:43

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

DOCUMENT # P02000115516

1. Corporation Name

LILLY'S MEDICAL EQUIPMENT, INC.

2. Principal Office Address - No P.O. Box #

3903 SW 78 CT.

3. Mailing Office Address

SAME

Suite, Apt. #, etc.

STE: 207

Suite, Apt. #, etc.

City & State

MIAMI, FL

City & State

Zip

33155

Country

Zip

Country

4. Date Incorporated or Qualified  
To Do Business in Florida

10/28/2002

5. FEI Number

13-4218731

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

JOSE A. CARRASCO

Street Address (P.O. Box Number is Not Acceptable)

3903 SW 78 CT.

Suite, Apt. #, Etc.

STE: 207

City

MIAMI

State

FL

Zip Code

33155



The reinstatement fee is imposed, except in  
circumstances which the entity did not receive  
the prior notices. By checking this box, you  
are certifying the prior notices were not  
received and requesting the reinstatement  
fee be waived.

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

REGISTERED AGENT MUST SIGN

Date

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
P/D	JOSE A. CARRASCO	3903 SW 78 CT.	MIAMI, FL 33155
			000112610470 11/27/07--01047--001 **\$600.00

**REINSTATEMENT**

04-07

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 contained in Chapter 119, 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 #

ECFS

PRESS CORPORATE FILING SERVICE, INC  
1000 PONCE DE LEON BLVD., STE: 101  
CORAL GABLES, FL 33134  
PH: (305)444-4994 FAX: (305)444-4977

RECEIVED  
07 NOV 20 AM 9:50  
DEPARTMENT OF STATE  
DIVISION OF CORPORATIONS  
TALLAHASSEE, FLORIDA

OFFICE USE ONLY

CORPORATION NAME(S) & DOCUMENT NUMBER(S) (if known):

P020000115516

1. Lillys Medical Equipment, Inc  
(Corporation Name) (Document #)
2. \_\_\_\_\_  
(Corporation Name) (Document #)
3. \_\_\_\_\_  
(Corporation Name) (Document #)
4. \_\_\_\_\_  
(Corporation Name) (Document #)

- ☐ Walk in ☒ Pick-up time ☐ Certified Copy  
☐ Mail out ☐ Will wait ☐ Photocopy ☐ Certificate of Status

NEW FILINGS	
<input type="checkbox"/>	Profit
<input type="checkbox"/>	NonProfit
<input type="checkbox"/>	Limited Liability
<input type="checkbox"/>	Domestication
<input type="checkbox"/>	Other

AMENDMENTS	
<input type="checkbox"/>	Amendment
<input type="checkbox"/>	Resignation of R.A., Officer/ Director
<input type="checkbox"/>	Change of Registered Agent
<input type="checkbox"/>	Dissolution/Withdrawal
<input type="checkbox"/>	Merger

OTHER FILINGS	
<input checked="" type="checkbox"/>	Annual Report
<input type="checkbox"/>	Fictitious Name
<input type="checkbox"/>	Name Reservation

REGISTRATION/ QUALIFICATION	
<input type="checkbox"/>	Foreign
<input type="checkbox"/>	Limited Partnership
<input checked="" type="checkbox"/>	Reinstatement
<input type="checkbox"/>	Trademark
<input type="checkbox"/>	Other

Examiner's Initials