

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

**CORPORATION  
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE  
Secretary of State  
DIVISION OF CORPORATIONS

2008 OCT 14 PM 12:07

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

DOCUMENT # P03000047423

**1. Corporation Name**

ARMONIA MEDICAL & REHABILITATION  
CENTER, INC.

300136984413  
10/16/08--01044--004 \*\*450.00

CR2E081 (10/08)

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

4915 E 1 CT

Suite, Apt. #, etc.

**3. Mailing Office Address**

4915 E 1 CT

Suite, Apt. #, etc.

**City & State**

Hialeah, FL

Zip Country

33015 US

**City & State**

Hialeah, FL

Zip Country

33015 US

**4. Date Incorporated or Qualified  
To Do Business in Florida**

4/29/03

**5. FEI Number**

173693566

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**

ORLANDO TORRES

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

4915 E 1 CT

**Suite, Apt. #, Etc.**

**City**

Hialeah

**State**

FL

**Zip Code**

33015

☒ 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 10/10/08

**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	ORLANDO TORRES	4915 E 1 CT	Hialeah, FL 33013

REINSTATEMENT

06-08  
988

**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

10/10/08

Daytime Phone #