PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

CORPORATION REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

FILED
04 OCT 25 PM 4:07
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P0300050656

1. Corporation Name
EXCELLENT CARE MEDICAL CENTER, INC.

4746 W FLAGLR STREET
4746 W FLAGLER STREET

REINSTATEMENT 2004

2. Principal Office Address		**3.** Mailing Office Address	
4746 W FLAGLR STREET		4746 W FLAGLER STREET	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State: MIAMI, FLORIDA		City & State: MIAMI, FLORIDA	
Zip: 33134	Country: USA	Zip: 33134	Country: USA

4. Date Incorporated or Qualified To Do Business in Florida

5. FEI Number: 13-4250998 ☐ 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: DIAZ, FIDEL

Street Address (P.O. Box Number is Not Acceptable): 4746 W FLAGLER STREET

Suite, Apt. #, Etc.:

City: MIAMI | State: FL | Zip Code: 33134

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 X _____ Date 10/13/04

REGISTERED AGENT MUST SIGN

CR2E081 (01/04)

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
DP	DIAZ, FIDEL	4746 W FLAGLER ST	MIAMI, FL 33134

700041938617
10/18/04--01061--023 **150.00

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)(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: X _____ 10/13/04 786-301-0625

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

October 13, 2004

Division of Corporations
Uniform Business Report Filing
P O Box 1500
Tallahassee, FL 32302-1500

Ref: Excellent Care Medical Center, Inc.
Doc. #P03000050656
Form: 2003 Annual Report

Dear Sir or Madame:

By some reason we did receive the notice of the Annual Report. Please accept to pay the amount of $150.00 for this time. We would like to state that this is the first time that will happen this discrepancy regarding my payment and unfortunately something that was not on our hands to correct before now.

Please find attached a check for the amount of $150.00. We hope that you pardon any late and accept our payment and we will be prompt to file in the future.

I would like to thank you in advance for your attention regarding this delicate matter. If more any additional information is needed please do not hesitate to contact us at the below address or at the following phone number 786-301-0625

Respectfully,

Excellent Care Medical Center, Inc.
4746 W Flagler St
Miami, FL 33134

Fidel Diaz
President