

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

1/2

**CORPORATION
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

FILED

06 APR 19 PM 1:42

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # 103000060847

1. Corporation Name

ALLIED HEALTHCARE FACILITIES INC.

2. Principal Office Address

1814 NE. MIAMI GARDENS DR.

Suite, Apt. #, etc.

#601

City & State

N. Miami, FL.

Zip

33179

Country

USA

3. Mailing Office Address

Suite, Apt. #, etc.

City & State

Zip

Country

CR2E081 (12/05)

REINSTATEMENT

4. Date Incorporated or Qualified
To Do Business in Florida

5. FEI Number

65-0265-241

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

JAY LIEBMAN

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

1814 NE. MIAMI GARDENS DR.

Suite, Apt. #, Etc.

#601

City

N. Miami

State

FL

Zip Code

33179

200072818582

04/28/06-01052-002 ***458.75

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

[Signature]

REGISTERED AGENT MUST SIGN

Date

4/19/06

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
Director	JAY LIEBMAN	1814 NE. Miami Gardens Dr. #601	N. Miami, FL. 33179

K-Echo: APR 10 2006

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 #

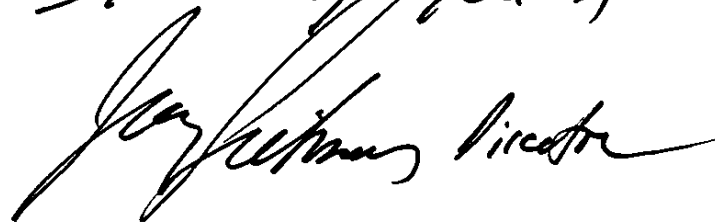
[Signature] 4/19/06

From: Allied Health Care Facilities, Inc.
1814 NE MIAMI GARDENS DR. #601
N. Miami, FL 33179

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To Whom It May Concern, 4/19/06

This letter is to inform you that
we did not receive the 2004-2005
Annual Report.

Sincerely yours,
 Director