1 of 2

2005 FOR PROFIT CORPORATION REINSTATEMENT

DOCUMENT # P04000039244

1. Entity Name
MEDICAL HEALTH PROVIDER, INC.

FILED
05 DEC 15 PM 5:35
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

Principal Place of Business	Mailing Address
16031 E PIMLICO DR LOXAHATCHEE, FL 33470	16031 E PIMLICO DR LOXAHATCHEE, FL 33470

REINSTATEMENT 2005

2. Principal Place of Business		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country

4. FEI Number 42-1620353 ☐ Applied For ☐ Not Applicable

5. Certificate of Status Desired ☐ $8.75 Additional Fee Required

6. Name and Address of Current Registered Agent

SED, DINORAH A
16031 E PIMLICO DR
LOXAHATCHEE, FL 33470

7. Name and Address of New Registered Agent

Name
Street Address (P.O. Box Number is Not Acceptable)
City FL Zip Code

8. The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. I am familiar with, and accept the obligations of registered agent.

SIGNATURE
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE

FILE NOW!!! FEE IS $150.00
After January 1, 2006, Fee will be $300.00

In accordance with s. 607.193(2)(b), F.S., the corporation did not receive the prior notice.

10. OFFICERS AND DIRECTORS			11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11		
TITLE	D	☐ Delete	TITLE		☐ Change ☐ Addition
NAME	SED, DINORAH A		NAME	900062198039	
STREET ADDRESS	16031 E PIMLICO DR		STREET ADDRESS	12/15/05--01032--012 **150.00	
CITY-ST-ZIP	LOXAHATCHEE, FL 33470		CITY-ST-ZIP		
TITLE		☐ Delete	TITLE		☐ Change ☐ Addition
NAME			NAME		
STREET ADDRESS			STREET ADDRESS		
CITY-ST-ZIP			CITY-ST-ZIP		
TITLE		☐ Delete	TITLE		☐ Change ☐ Addition
NAME			NAME		
STREET ADDRESS			STREET ADDRESS		
CITY-ST-ZIP			CITY-ST-ZIP		
TITLE		☐ Delete	TITLE		☐ Change ☐ Addition
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CITY-ST-ZIP			CITY-ST-ZIP		
TITLE		☐ Delete	TITLE		☐ Change ☐ Addition
NAME			NAME		
STREET ADDRESS			STREET ADDRESS		
CITY-ST-ZIP			CITY-ST-ZIP		
TITLE		☐ Delete	TITLE		☐ Change ☐ Addition
NAME			NAME		
STREET ADDRESS			STREET ADDRESS		
CITY-ST-ZIP			CITY-ST-ZIP		

12. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(i), Florida Statutes. I further certify that the information indicated on this report or supplemental report is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am an officer or director of the corporation or the receiver or trustee empowered to execute this report as required by Chapter 607, Florida Statutes; and that my name appears in Block 10 or Block 11 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE: Dinorah A. SED 12/09/05
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

2852

December 12, 2005

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

Re: MEDICAL HEALTH PROVIDER, INC.
P04000039244
Reinstatement

To Whom It May Concern:

Enclosed find check for $150.00 to pay for the 2005 Annual Report. I never received the original notice and I did not know the Corporation had been dissolved.

Sincerely,

Dinorah A. Sed