


2005 FOR PROFIT CORPORATION REINSTATEMENT

DOCUMENT # P04000039244 1. Entity Name MEDICAL HEALTH PROVIDER, INC.						FILED 05 DEC 15 PM 5:35 SEC. OF STATE TALLAHASSEE, FL	
Principal Place of Business 16031 E PIMLICO DR LOXAHATCHEE, FL 33470				Mailing Address 16031 E PIMLICO DR LOXAHATCHEE, FL 33470			
2. Principal Place of Business Suite, Apt. #, etc.				3. Mailing Address Suite, Apt. #, etc.			
City & State				City & State			
Zip		Country		Zip		Country	
4. FEI Number 42-1620353				Applied For <input type="checkbox"/> Not Applicable			
5. Certificate of Status Desired <input type="checkbox"/>				\$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 <div style="display: flex; justify-content: space-between;"> FL Zip Code </div>			
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 _____ <small>Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating) DATE</small>							
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 NAME STREET ADDRESS CITY-ST-ZIP	D <input type="checkbox"/> Delete SED, DINORAH A 16031 E PIMLICO DR LOXAHATCHEE, FL 33470			TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition 900062198039 12/15/05--01032--012 **150.00		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete			TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete			TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete			TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition		
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TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete			TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition		
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: <u><i>Dinorah A. SED</i></u> Dinorah A. SED 12/09/05 <small>SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #</small>							

December 12, 2005

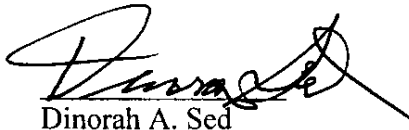
Florida Department of State
Division of Corporations
P.O. Box 6327
Tallahassee, Fl. 32314

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