1/2

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM. FILED

2006 OCT -6 AM 11:03

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

CORPORATION REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # P05000028877

1. Corporation Name
TAMPA HEALTH CARE SUPPLIES, INC.

REINSTATEMENT 06

CR2E081 (8/05)

2. Principal Office Address	3. Mailing Office Address
4602 N. Armenia Ave	4602 N. Armenia Ave
Suite, Apt. #, etc. Suite D2 Tampa	Suite, Apt. #, etc. D2
City & State Tampa, FL	City & State Tampa, FL
Zip 33603 County	Zip 33603 County

4. Date Incorporated or Qualified To Do Business in Florida 3/9/05

5. FEI Number 550891068 ☐ Applied For ☐ Not Applicable

6. CERTIFICATE OF STATUS DESIRED ☐ $8.75 Additional Fee Required for Certificate of Status

7. Name and Address of Current Registered Agent

Name: GRETEL QUINONES

Street Address (P.O. Box Number is Not Acceptable): 4602 N. Armenia Ave.

Suite, Apt. #, Etc.: Suite D2

City: Tampa State: FL Zip Code: 33603

I. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of section 607.0505 or 617.0505, F.S.

Signature of Registered Agent: _____ Date: _____

REGISTERED AGENT MUST SIGN

II. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at least 3 directors)

Title	Name of Officers and/or Directors	Street Address of Each Officer and/or Director	City / State / Zip
P	GRETEL QUINONES	4602 N. ARMENIA #D2	TAMPA, FL 33603

10/11/06--01021--007 **150.00

III. 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: _____

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

10/6/06

DATE:_____

FL. DEPARTMENT OF STATE
ANNUAL REPORT

PER OUR CONVERSATION PLEASE CHECK YOUR RECORDS THAT MY CORPORATION TAMPA HEALTH CARE Supplies INC.
DOCUMENT # P05000028877
NEVER RECEIVED THE ANNUAL REPORT THIS YEAR. PLEASE ACCEPT OUR PAYMENT WITHOUT PENALTY DUE TO THAT WE NEVER RECEIVED THE REPORT.

THANKING YOU IN ADVANCE

SIGNATURE

GRETEL QUINONE (President)
PRINT NAME/ TITLE