

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM

FILED

112

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 Suite D2

City & State

City & State

City & State

City & State

Zip

Country

Zip

Country

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 ☐

7. Additional Fee Required  
for a 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, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of section 607.0605 or 617.0508, F.S.

Signature of  
Registered Agent

[Signature]

Date

REGISTERED AGENT MUST SIGN

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

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

10/11/06--01021--007 \*\*192.00

I, 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

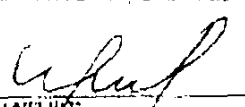
DATE: \_\_\_\_\_

FL. DEPARTMENT OF STATE  
ANNUAL REPORT

PER OUR CONVERSATION PLEASE CHECK YOUR RECORDS THAT MY  
CORPORATION TAMPA HEALTH CARE SUPPLIES  
DOCUMENT # PO50000 28877 INC.

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

  
SIGNATUREGRACIELA QUINONE  
PRINT NAME/TITLE

(President)