


# 2009 FOR PROFIT CORPORATION REINSTATEMENT

DOCUMENT # P06000015292	
1. Entity Name METROPOLITAN MEDICAL STAFF FUND, INC.	

FILED  
09 MAR 16 PM 2:51  
SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

Principal Place of Business 351 NW LE JEUNE RD 204 MIAMI, FL 33126	Mailing Address 351 NW LE JEUNE RD 204 MIAMI, FL 33126
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2. Principal Place of Business - No P.O. Box # 5959 NW 7th STREET Suite, Apt. #, etc. MEDICAL STAFF DEPT City & State MIAMI, FL Zip 33126 Country USA	3. Mailing Address 5959 NW 7th STREET Suite, Apt. #, etc. MEDICAL STAFF DEPT City & State MIAMI, FL Zip 33126 Country USA
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4. FEI Number 20-4216521	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 GARRIDO, ANGEL M.D. 351 NW LE JEUNE RD. 204 MIAMI, FL FL	
7. Name and Address of New Registered Agent Name JOSE ALBERTO ALEA, M.D. Street Address (P.O. Box Number is Not Acceptable) 5959 NW 7th STREET City MIAMI FL Zip Code 33126	

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: JOSE ALBERTO ALEA, MD DATE: 03/12/09

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

FILE NOW!!! FEE IS \$300.00	In accordance with s. 607.193(2)(b), F.S., the corporation did not receive the prior notice.
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10. OFFICERS AND DIRECTORS		11. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 11	
TITLE NAME STREET ADDRESS CITY-ST-ZIP	P ALEA, JOSE A M.D. 6232 LEONARDO STREET CORAL GABLES, FL 33146 <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	VP GARRIDO, ANGEL E M.D. 351 N.W. LE JEUNE ROAD, SUITE 204 MIAMI, FL 33126 <input checked="" type="checkbox"/> Delete	TITLE NAME STREET ADDRESS CITY-ST-ZIP	500145938135 03/16/09--01051--018 **308.75 <input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP	ST VILA, RUAL I M.D. 5959 N.W. 7TH STREET, LABORATORY DEPT. MIAMI, FL 33126 <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
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 exemptions contained in Chapter 119, 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: *Jose Alberto Alea, M.D.* *alea* 305 772 7610

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