

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

**CORPORATION
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

FILED

09 DEC 21 PM 12:37

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # **P07000051562**

1. Corporation Name

S.T. NURSING CARE, INC.

2. Principal Office Address - No P.O. Box #

8902 NW 178 LN

Suite, Apt. #, etc.

City & State

Miami FL

Zip

33018

Country

Miami-

3. Mailing Office Address

8902 NW 178 LN

Suite, Apt. #, etc.

City & State

Miami FL

Zip

33018

Country

USA

CR2E081 (1/07)

4. Date incorporated or Qualified
To Do Business in Florida

4/27/07

5. FEI Number

208923283

Applied For

Not Applicable

6. CERTIFICATE OF STATUS DESIRED ☐

\$8.75 Additional Fee required
for a Certificate of Status

7. Name and Address of Current Registered Agent

Name

Sonia Torredemart

Street Address (P.O. Box Number is Not Acceptable)

8902 NW 178 LN

Suite, Apt. #, Etc.

City

Miami

State

FL

Zip Code

33018



The reinstatement fee is imposed, except in
circumstances which the entity did not receive
the prior notices. By checking this box, you
are certifying the prior notices were not
received and requesting the reinstatement
fee be waived.

8. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of section 607.0505 or 617.0503, F.S.

Signature of
Registered Agent

Date

REGISTERED AGENT MUST SIGN

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

Titles	Name of Officers and/or Directors	Street Address of Each Officer and/or Director	City / State / Zip
P	Sonia Torredemart	8902 NW 178 LN	Miami FL 33018

400163825054
12/21/09--01035--009 **150.00

10. 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 contained in Chapter 119, 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 #