

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

FILED

01 AUG 20 AM 3:20

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

CORPORATION REINSTATEMENT 		FLORIDA DEPARTMENT OF STATE Katherine Harris Secretary of State DIVISION OF CORPORATIONS	
DOCUMENT # P07284 1. Corporation Name Insta-Care Pharmacy Services Corporation			
2. Principal Office Address 175 Kelsey Lane Suite, Apt. #, etc.		3. Mailing Office Address 4000 Metropolitan Drive Suite, Apt. #, etc.	
City & State Tampa, FL Zip 33619		City & State Orange, CA Zip 92868	
Country USA		Country USA	
4. Date Incorporated or Qualified To Do Business in Florida 08/26/1985			
5. FEI Number 59-1817412		Applied For <input type="checkbox"/> Not Applicable	
6. CERTIFICATE OF STATUS DESIRED <input checked="" type="checkbox"/> \$8.75 Additional Fee required for a Certificate of Status			

7. Name and Address of Current Registered Agent Name CT Corporation System Street Address (P.O. Box Number is Not Acceptable) 1200 South Pine Island Road. Suite, Apt. #, Etc. City Plantation		300004569053--1 09/05/01--01017--002 ***750.00 ***50.00 300004569053--1 09/05/01--01017--003 ***750.00 ***50.00 State FL 33324
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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.

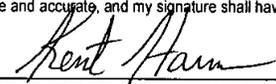
Signature of Registered Agent:  **M.T. FITZPATRICK**
 REGISTERED AGENT MUST SIGN **ASSISTANT SECRETARY** Date **AUG 17 2001**

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 09/05/01 01017 004
 *****8 75 *****8 75

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
PCEO	Charles J. Carpenter	175 Kelsey Lane	Tampa, FL 33619
EVP	Neil F. Dimick	4000 Metropolitan Drive	Orange, CA 92868
T	Michael Montevideo	4000 Metropolitan Drive	Orange, CA 92868
Asst Sec	Kent Harms	4000 Metropolitan Drive	Orange, CA 92868
D	Milan A. Sawdei	4000 Metropolitan Drive	Orange, CA 92868
			<i>mw</i>

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 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:  **Kent Harms, Assistant Secretary** (714) 385-4000
 SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CT CORPORATION SYSTEM

CORPORATION(S) NAME

Insta-Care Pharmacy Services Corporation

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- | | | |
|--|---|---|
| <input type="checkbox"/> Profit | <input type="checkbox"/> Amendment | <input type="checkbox"/> Merger |
| <input type="checkbox"/> Nonprofit | | |
| <input type="checkbox"/> Foreign | <input type="checkbox"/> Dissolution/Withdrawal | <input type="checkbox"/> Mark |
| | <input checked="" type="checkbox"/> Reinstatement | |
| <input type="checkbox"/> Limited Partnership | <input type="checkbox"/> Annual Report | <input type="checkbox"/> Other |
| <input type="checkbox"/> LLC | <input type="checkbox"/> Name Registration | <input type="checkbox"/> Change of RA |
| | <input type="checkbox"/> Fictitious Name | <input type="checkbox"/> UCC |
| <input type="checkbox"/> Certified Copy | <input type="checkbox"/> Photocopies | <input checked="" type="checkbox"/> CUS |
| <input type="checkbox"/> Call When Ready | <input type="checkbox"/> Call If Problem | <input type="checkbox"/> After 4:30 |
| <input checked="" type="checkbox"/> Walk In | <input type="checkbox"/> Will Wait | <input checked="" type="checkbox"/> Pick Up |
| <input type="checkbox"/> Mail Out | | |

Name _____ 8/20/01 Order#: 4738143
 Availability _____
 Document _____
 Examiner _____ Ref#: _____
 Updater _____
 Verifier _____
 W.P. Verifier _____

Amount: \$ _____

DIVISION OF CORPORATION

01 AUG 20 AM 11:25

RECEIVED

660 East Jefferson Street
 Tallahassee, FL 32301
 Tel. 850 222 1092
 Fax 850 222 7615