PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

CORPORATION REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

400438851084
10/30/24--01006--023 **1103.75

DOCUMENT # P12000023858

1. Corporation Name

QUALITY HEALTHCARE SYSTEMS CORP

CR2E081 (11/10)

2. Principal Office Address - No P.O. Box #	3. Mailing Office Address
41 SE 5 ST	41 SE 5 ST
Suite, Apt. #, etc.	Suite, Apt. #, etc.
Apt 709	Apt 709
City & State	City & State
Miami, Florida	Miami, Florida
Zip / Country	Zip / Country
33131 / USA	33131 / USA

4. Date Incorporated or Qualified To Do Business in Florida: 03/09/2012

5. FEI Number: 45-4763032 ☐ Applied For ☐ Not Applicable

6. CERTIFICATE OF STATUS DESIRED: Yes — $8.75 Additional Fee required for a Certificate of Status

7. Name and Address of Current Registered Agent

Name: Karla M Arrechea

Street Address (P.O. Box Number is Not Acceptable): 41 SE 5 ST

Suite, Apt. #, Etc.: Apt 709

City: MIAMI | State: FL | Zip Code: 33131

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 10/18/2024

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 / T	Karla M Arrechea	41 SE 5 ST Apt 709	MIAMI, FL.33131

10. E-mail Address: qhs3467@gmail.com

(To be used for future annual report notification)

11. 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., and that all fees owed by the corporation have been paid. I further certify, the information indicated on this application is true and accurate, and my signature shall have the same legal effect as if made under oath. I am aware that false information submitted in a document to the Department of State constitutes a third degree felony as provided for in s. 817.155, F.S.

SIGNATURE: _____ Karla M Arrechea 10/18/2024 305 773-6049

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