

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 01-11-2011 BY 60322
2021 DEC 31 PM 12:07

**CORPORATION
REINSTATEMENT**


FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # 813000096972

1. Corporation Name

Promise Healthcare #2, Inc.

2. Principal Office Address - No P.O. Box #
c/o Advisory Trust Group, LLC 10645
N. Oracle Road,
Suite, Apt. #, etc.

Suite 1211-371

City & State

Oro Valley, AZ

Zip

85737

Country

USA

3. Mailing Office Address
c/o Advisory Trust Group, LLC 10645
N. Oracle Road
Suite, Apt. #, etc.

Suite 1211-371

City & State

Oro Valley, AZ

Zip

85737

Country

USA

800378984028

CR2E081 (11/10)

4. Date Incorporated or Qualified
To Do Business in Florida

12/02/2013

5. FEI Number

90-1031913

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

Corporation Service Company

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

1201 Hays Street

Suite, Apt. #, Etc.

City

Tallahassee

State

FL

Zip Code

32301

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

Eyluma Bahar
Assistant Vice President

Date 01/03/2022

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
Debtor Rep.	Bob Michaelson	c/o Advisory Trust Group, LLC 10645 N. Oracle Road, Suite 1211-371	Oro Valley, AZ 85737
			DEC 31 2021
			R. HUNT

10. E-mail Address: bob.michaelson@advisorytlk.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:

Bob Michaelson

Bob Michaelson

12-22-2021

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

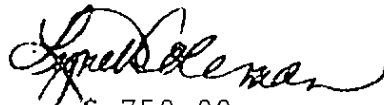
Daytime Phone #

CORPORATION SERVICE COMPANY
1201 Hays Street
Tallahassee, FL 32301
Phone: 850-558-1500

ACCOUNT NO. : I20000000195

REFERENCE : 354896 4814048

AUTHORIZATION



COST LIMIT : \$750.00

ORDER DATE : December 29, 2021

ORDER TIME : 2:09 PM

ORDER NO. : 354896-055

CUSTOMER NO: 4814048

DOMESTIC FILINGS

NAME: PROMISE HEALTHCARE #2, INC.

XX REINSTATEMENT

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

 CERTIFIED COPY
XX PLAIN STAMPED COPY
 CERTIFICATE OF GOOD STANDING

CONTACT PERSON: Eyliena Baker - Ext#

EXAMINER'S INITIALS _____

2022 JAN -4 PM 4:27