H00000005332 2 PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Sandra B. Mortham
Secretary of State
DIVISION OF CORPORATIONS

FILED
SECRETARY OF STATE
DIVISION OF CORPORATIONS

00 FEB -2 PM 4:01

DOCUMENT # P94000042800

1. Corporation Name

MEDICAL CARE CENTER, INC.

REINSTATEMENT 99-L-

Principal Place of Business	Mailing Address
461 E. HIALEAH DR. HIALEAH, FL. 33013	461 E. HIALEAH DR. HIALEAH, FL. 33013

If above addresses are incorrect in any way, line through incorrect information and enter correction below.

2. New Principal Office Address, If Applicable	3. New Mailing Office Address, If Applicable
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State	City & State
Zip / Country	Zip / Country

4. Date Incorporated or Qualified To Do Business in Florida: 06/08/1994

5. FEI Number: 65-0496628 — Applied For / Not Applicable

6. CERTIFICATE OF STATUS DESIRED [X] $8.75 additional fee required for a Certificate of Status

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

1 Title(s)	2 Name of Officers and/or Directors	3 Street Address of Each Officer and/or Director (Do NOT Use Post Office Box Numbers)	4 City / State / Zip
P.D	EGUSQUIZA, JORGE	461 E. HIALEAH DR	HIALEAH, FL. 33010

8. Name and Address of Current Registered Agent

EGUSQUIZA, JORGE
1925 E. 4 AVE SUITE 1
HIALEAH, FL. 33013

9. Name and Address of New Registered Agent

Name: EGUSQUIZA, JORGE
Street Address (P.O. Box Number is Not Acceptable): 461 E. HIALEAH DR
Suite, Apt. #, Etc.:
City: HIALEAH — State: FL — Zip Code: 33010

CR2E040 (1-95)

10. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of Section 607.0505, F.S.

Signature of Registered Agent: [signature] REGISTERED AGENT MUST SIGN — Date: 2/1/00

11. This corporation owes or has paid the current year Intangible Personal Property tax due June 30. Yes [X] No [ ] (See other side for information on intangible tax.)

12. 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: [signature] JORGE EGUSQUIZA — 2/1/00 — 305-889-6665
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

AD

Florida Department of State

Division of Corporations

Public Access System

Katherine Harris, Secretary of State

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(((H00000005332 2)))

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To:
Division of Corporations
Fax Number : (850)922-4004

From:
Account Name : FAS-T CORP. AGENTS, INC.
Account Number : 071001002335
Phone : (305)599-0839
Fax Number : (305)716-0346

CORPORATION REINSTATEMENT

MEDICAL CARE CENTER, INC.

Certificate of Status	0
Certified Copy	0
Page Count	01
Estimated Charge	$900.00