

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

**CORPORATION  
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE  
Secretary of State  
DIVISION OF CORPORATIONS

FILED  
SECRETARY OF STATE  
DIVISION OF CORPORATIONS

05 AUG 12 AM 11:07

DOCUMENT # **P94000046435**

1. Corporation Name

HEALTHCARE DISTRIBUTORS, INC.

W05-14040

2. Principal Office Address

624 ROYAL PLAZA DR.

Suite, Apt. #, etc.

3. Mailing Office Address

624 ROYAL PLAZA DR.

Suite, Apt. #, etc.

City & State

FT. LAUDERDALE, FL

Zip

33301

Country

USA

City & State

FT. LAUDERDALE, FL

Zip

33301

Country

USA

**REINSTATEMENT 02-05**

4. Date Incorporated or Qualified  
To Do Business in Florida

6/17/94

5. FEI Number

65-0504616

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

MIKE S. AMENT

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

624 ROYAL PLAZA DR.

Suite, Apt. #, Etc.

City

FT. LAUDERDALE

State

FL

Zip Code

33301

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

*Michael S. Ament*  
REGISTERED AGENT MUST SIGN

Date

3/09/05

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
D	MICHAEL S. AMENT	624 ROYAL PLAZA DR.	FT. LAUDERDALE, FL 33301

100058697051  
08/17/05--01043--024 \*\*608.75

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:

*Michael S. Ament*  
SIGNATURE AND PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

MICHAEL S. AMENT

3-9-05

Date

9547631772

Daytime Phone #

CR2E081 (01/05)

Gregg T. Kirk, P.C. & Associates  
CERTIFIED PUBLIC ACCOUNTANTS

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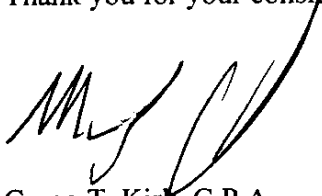
August 8, 2005

FLORIDA DEPARTMENT OF STATE  
Secretary of State  
Division of Corporations  
P.O. Box 6327  
Tallahassee, FL 32314

To Whom it May Concern:

This letter is a written request to waive the reinstatement fee for Healthcare Distributors Inc. We need to file 2001, 2002, 2003 & 2004 forms with you after the reinstatement. The Administrative Dissolution occurred on October 4, 2002. The taxpayer's address has changes three times in the last three years and the mail from the State of Florida has not kept up with his changing address. The mailing address for this corporation on your website is incorrect and we had not received previous notices regarding the Annual Reports or the Administrative Dissolution. It has always been our intention to file these reports timely, but we did not receive notices at our office, nor did the taxpayer receive the notices in his forwarded mail from his previous addresses. We are submitting the Corporation Reinstatement Form with this letter which contains the Corporation's current address and change of Registered Agent. Also included is a check to the State of Florida in the amount of \$608.75 to relieve the taxpayer of penalties per instructions from your office. We will file all the necessary reports to reinstate this Corporation once we have heard from you regarding what is missing.

Thank you for your consideration in this matter,



Gregg T. Kirk, C.P.A.