


102

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

CORPORATION REINSTATEMENT	 FLORIDA DEPARTMENT OF STATE Secretary of State DIVISION OF CORPORATIONS
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FILED

04 JUL 28 PM 12:43

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # **P95000049279**

1. Corporation Name

L & A Medical Equipment

2. Principal Office Address

5900 W 20 Ave

Suite, Apt. #, etc.

G

City & State

Hia. Fla

Zip

33016

Country

US

3. Mailing Office Address

2616 W 68 Pl

Suite, Apt. #, etc.

City & State

Hia. Fla

Zip

33016

Country

US

REINSTATEMENT

00-04
MRS

4. Date Incorporated or Qualified
To Do Business in Florida

06/23/95

5. FEI Number

65-0590457

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

Gonzalez Luis S.

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

2616 W 68 Pl

Suite, Apt. #, Etc.

City

Hia.

100039733841
07/30/04--01057--013 **250.00

100039733841
07/30/04--01057--014 **500.00

State

FL

Zip Code

33016

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 **7-26-04**

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
PRES.	Gonzalez Luis S.	2616 W 68 Pl.	Hia. Fla 33016

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:



SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

7/26/04

Date

305-5127357

Daytime Phone #

CP25081 (01/04)

FAX NO. : 362-1733

Jul. 27 2004 12:48PM P1

Zg~

7-27-04

To whom it may concern.

This is to notify that L&A Medical
Equipment Inc. did not received the
2000 Annual report of the corporation
Please waive 600.00

Thank you
