PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

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	RPORAT ISTATEM			FLOF	Kather Secreta	RTMENT OF ine Harris ry of State CORPORATION	Ÿ		JAN	FILED			
DOCUMENT # P950000 51902								SECRETARY OF STATE TALLAHASSEE, FLORIDA					
C.A.R. MEDICAL EQUIPMENT, INC.											•	,	
	al Office Addres		reet	4	3. Mailing Office Address 5993 SW 8th Street								
Suite, Apt. #, etc.				Suite,	Suite, Apt. #, etc.				4. Date Incorporated or Qualified To Do Business in Florida				
City & State Miami, FL				1 .	City & State Miami, FI			5. FEI Number — Applies 65-0597643 Not Ap					
Zip 331,4	4 Country USA			Zip 331	44	Country USA	#2, ™ &± ±±6.	6. CERTIFICATE OF STATUS DESIRED				dditional Fee Certificate of	
	To Name and Address of Current Registered Agent Name												
8. I, being Signature o Registered	1 .	registered	lagent of the	oligations of section		05 or 617.050							
9. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at lease								ast 3 directors)					
Titles	Name of Officers and/or Directors								<u> </u>		y / State / Z		
D/P/V T/S	Edmund	o Fe	rnandez	Z,	5993	SW 8th	Street	·	Miar	ni, Fl	3314	4 	
							<u> </u>			5490 10101 .00 **			
		·		Fig. 183 Fig.	ETAT	EMEN	<u> </u>)-01	T	3			
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 fill 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 ferowed by the corporation have been part 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 indication this application is true and accurate, analysis signature shall have the same legal effect as if made under oath.													

SIGNATURE SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

1/18/01

Daylime Phone #