



FLORIDA DEPARTMENT OF STATE
Katherine Harris
Secretary of State
DIVISION OF CORPORATIONS

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SECRETARY OF STATE
TALLAHASSEE, FLORIDA

1. Corporation Name

C.A.R. MEDICAL EQUIPMENT, INC.

Suite, Apt. #, etc.

City & State
Miami, FL

Country
USA

Applies
Not Ap

6. CERTIFICATE OF STATUS DESIRED ☐ \$8.75 Additional Fee for a Certificate of

Name _____

Suite, Apt. #, Etc.

City

State
FL

Zip Code
33144

Signature of
Registered Agent

Date 1/18/01

REGISTERED AGENT MUST SIGN

[illegible]

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****935.00 ****900.00

STATEMENT	00-01	78
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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)(f), 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

1/18/01

Date _____

Daytime Phone #