


PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

<b>CORPORATION REINSTATEMENT</b>		<b>FLORIDA DEPARTMENT OF STATE Secretary of State DIVISION OF CORPORATIONS</b>
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FILED  
05 DEC 30 PM 1:15

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

DOCUMENT # P95000058938

1. Corporation Name

HELP MEDICAL EQUIPMENT INC.

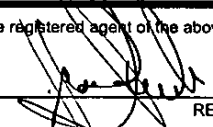
REINSTATEMENT 05

CR2E081 (8/05)

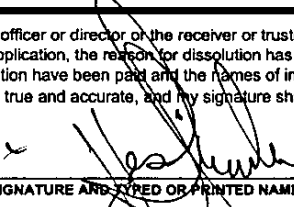
2. Principal Office Address 2246 W 80TH STREET		3. Mailing Office Address SAME	
Suite, Apt. #, etc. UNIT # 8		Suite, Apt. #, etc. SAME	
City & State HIALEAH, FL. 33016		City & State SAME	
Zip 33016	Country MIAMI DADE	Zip	Country

4. Date Incorporated or Qualified To Do Business in Florida 07/27/1995	
5. FEI Number 65-0597221	<input type="checkbox"/> Applied For <input type="checkbox"/> Not Applicable
6. CERTIFICATE OF STATUS DESIRED <input type="checkbox"/> \$8.75 Additional Fee required for a Certificate of Status	

7. Name and Address of Current Registered Agent	
Name JUAN INDA	
Street Address (P.O. Box Number is Not Acceptable) 8777 N.W. 110 STREET	
Suite, Apt. #, Etc. 12/30/05--01045--005 **10.00	
City HIALEAH GARDEN	
State FL	Zip Code 33018

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 12/28/05
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
P[R	JUAN INDA	8777 N.W. 110 STREET	HIALEAH GARDEN 33018

10. I certify that I am an officer or director of 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: 	12/28/2005 (305)822-6606
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR	Date Daytime Phone #

DECEMBER 28, 2005

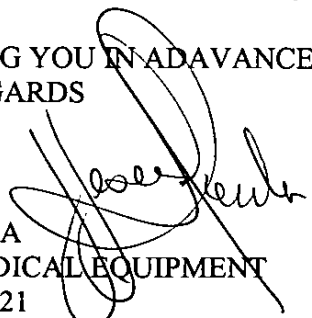
**REFERENCE:**

**2005 ANNUAL REPORT**

**TO: WHOM IT MAY CONCERN**

IN REFERENCE TO THE LETTER ATTACHED (DOCUMENT # P95000058938, 2005 ANNUAL REPORT), I, JUAN INDA, WOULD LIKE TO CONFIRM THAT I NEVER RECEIVED ANY NOTIFICATION OR NOTICE OF SHORT PAYMENT. I WOULD LIKE TO REQUEST A WAVE FOR ANY PENALTIES I MAY HAVE, SINCE I WAS NOT AWARE OF THIS FACT, AND I APPOLOGIZE FOR ANY INCONVINIECE THIS MAY CAUSE.

THANKING YOU IN AD AVANCE  
BEST REGARDS



JUAN INDA  
HELP MEDICAL EQUIPMENT  
SUITE #7421  
HIALEAH, FL. 33012