PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

1052

CORPORATION ~~REINSTATEMENT~~

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

FILED
01 DEC 27 PM 5:49
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

900004883029--4
-02/06/02--01042--020
****158.75 ****158.75

2001 UBR

DOCUMENT # P97000015930

1. Corporation Name
HEALTH CARE & REHABILITATION CENTER INC

2. Principal Office Address	3. Mailing Office Address
845 E. 10TH AVE	P.O. BOX 836330
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State: HIALEAH, FL	City & State: MIAMI, FL
Zip: 33010 Country: USA	Zip: 33283 Country: USA

4. Date Incorporated or Qualified To Do Business in Florida: 2-19-1997

5. FEI Number: 65-0729119 ☐ 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: WALTER BRANDO

Street Address (P.O. Box Number is Not Acceptable): 845 EAST 10TH AVE

Suite, Apt. #, Etc.:

City: HIALEAH | State: FL | Zip Code: 33010

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: X _____ REGISTERED AGENT MUST SIGN Date: 11-7-01

CR2E081 (9/00)

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.	WALTER BRANDO	845 EAST 10 AVE	HIALEAH, FL 33010
TRES.	WALTER BRANDO	845 EAST 10 AVE	HIALEAH, FL 33010
SEC.	WALTER BRANDO	845 EAST 10 AVE	HIALEAH, FL 33010

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: X _____ 11-7-01
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

252

Health Care & Rehabilitation Center,

845 East 10' th Avenue♦ Hialeah, Florida 33010-4645♦ Tel: 305-888-2310 Fax: 305-888-1503

November 7, 2001

Division of Corporations
Annual Report / Reinstatement Section
P.O. Box 6327
Tallahassee, Fl. 33214-6327

To Whom It May Concern:

Please accept this check for reinstatement fee for my Corporation. After several lost documents I had to rent a Post Office Box for Health Care & Rehabilitation Center Inc. I never received the original uniform notice.

Your cooperation is greatly appreciated.

Mr. Walter Brando
President
Health Care & Rehabilitation Center Inc.
P.O.Box 836330
Miami, Fl. 33283-6330