

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

**CORPORATION
REINSTATEMENT**



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

FILED

02 APR 29 AM 8:46

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # **P 98000005369**

1. Corporation Name

CAC MEDICAL, Inc

2. Principal Office Address

1328 Eckels DR

Suite, Apt. #, etc.

City & State

Tampa FL

Zip

33612

Country

USA

3. Mailing Office Address

1328 Eckels DR

Suite, Apt. #, etc.

City & State

Tampa FL

Zip

33612

Country

USA

4. Date Incorporated or Qualified
To Do Business in Florida

1/16/98

5. FEI Number

59-3488955

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

CAROLYN CONRAD

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

1328 Eckels DR

Suite, Apt. #, Etc.

City

Tampa

State

FL

Zip Code

33612

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

[Signature]

REGISTERED AGENT MUST SIGN

Date

042502

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
DP	CAROLYN CONRAD	1328 Eckels DR	Tampa FL 33612

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

CAROLYN CONRAD MEADOWS

Date

042502

Daytime Phone #

813-930-8454

CR2E081 (9/99)