PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

CORPORATION REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

FILED
SECRETARY OF STATE
DIVISION OF CORPORATIONS
03 FEB 20 PM 1:12

DOCUMENT # . P98000052073

1. Corporation Name

CARE FIRST MEDICAL CENTER, INC.

100013697181
03/07/03--01062--035 **150.00

100013697181
03/07/03--01062--034 **150.00

2. Principal Office Address	3. Mailing Office Address
115 PONCE DE LEON BLVD	115 PONCE DE LEON BLVD
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State: CORAL GABLES, FL	City & State: CORAL GABLES, FL
Zip: 33135 Country: USA	Zip: 33135 Country: USA

4. Date Incorporated or Qualified To Do Business in Florida: 6/01/98

5. FEI Number: 65-0843258 ☐ 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: DANIEL KEIL

Street Address (P.O. Box Number is Not Acceptable): 3165 WEST 4TH AVENUE

Suite, Apt. #, Etc.:

City: HIALEAH State: FL Zip Code: 33012

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 _____

REGISTERED AGENT MUST SIGN

CR2E081 (10/02)

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 Officers and/or Director	City/State/Zip
PR	LUIS F MARTINEZ	2255 SW 22ND TERRACE	MIAMI, FL 33135
VPR	JOSEFA REYES	13458 SW 62ND ST #Q105	MIAMI, FL 33183

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: ✓ Luis Martinez ✓ 2/19/03 305 774-9920

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

STF FL32524F.1

GREENWALD GLAUSER & ROSS, P.A.
Certified Public Accountants

DADE (305) 931-1265
BROWARD (954) 523-8144
FAX (305) 931-4158

Florida Department of State
Division of Corporations
P.O. Box 6327
Tallahassee, Florida 32314

To Whom It May Concern:

Please find enclosed a Reinstatement Application for Care First Medical Center, Inc. I hope you will accept this reinstatement, due to the fact they never received the original Uniform Business Form. As I explained to a supervisor, they mailed a check in the amount of $150.00 but with the wrong Uniform Business Form.

Along with the reinstatement form are two check in the amount of $150.00 each. That is the fee for the years 2001 & 2002.

Thanking you in advance for your cooperation in this matter.

Sincerely,

Juanita Sankovich

18305 BISCAYNE BOULEVARD • SUITE 302 • AVENTURA, FLORIDA 33160