PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

CORPORATION REINSTATEMENT

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

FILED
SECRETARY OF STATE
DIVISION OF CORPORATIONS
01 JAN -2 PM 3:11

DOCUMENT # P98000081944

1. Corporation Name
ALL FAMILY WORKMAN MEDICAL CENTER INC.

2. Principal Office Address	3. Mailing Office Address
995 ROCK ISLAND Rd	995 ROCK ISLAND RD
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State: N. LAUDERDALE	City & State: N. LAUDERDALE
Zip: 33068 Country: Broward	Zip: 33068 Country: BROWARD

4. Date Incorporated or Qualified To Do Business in Florida: 09-08-1998

5. FEI Number: 650862186 — X 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: Emmanuel Eloi

Street Address (P.O. Box Number is Not Acceptable): 995 ROCK ISLAND Rd

Suite, Apt. #, Etc.:

City: N. Lauderdale State: FL Zip Code: 33068

300003535273--8
-01/12/01--01024--003
****300.00 ****300.00

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: _____ REGISTERED AGENT MUST SIGN Date: 12-14-00

CR2E081 (9/99)

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
DIRECTOR	EMMANUEL ELOI	995 ROCK ISLAND RD	N. LAUDERDALE FL 33068

$1.1/3/01

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.

EMMANUEL ELOI, MD

SIGNATURE: _____ 12-14-00

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

December 14, 2000

Division of Corporations
P.O Box 6327
Tallahassee, Fl 32314

I'm sorry my statement
To Renew my TAKE I D DID Come
To my new LOCATION, THEREFORE
I WILL LIKE TO REINSTATED FEI Number
650862186.
ENCLOSED is a check of
$300.00 PAST due.

Sincerely,

ALL FAMILY MEDICAL
Emmanuel Elo, M.D.
995 Rock Island Road
North Lauderdale, FL. 33068
Tel: (954) 720-5007