PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

CORPORATION REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

FILED
05 AUG 31 PM 12:15
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

100059382861
09/07/05--01016--006 **900.00

DOCUMENT # P99000002428

1. Corporation Name
P.M. MEDICAL CENTER, INC.

2. Principal Office Address	3. Mailing Office Address
3970 SW 67 AVE	3970 SW 67 AVE.
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State: MIAMI, FLORIDA	City & State: MIAMI, FLORIDA
Zip: 33155 Country: DADE	Zip: 33155 Country: DADE

4. Date Incorporated or Qualified To Do Business in Florida: 01/07/1999

5. FEI Number: 65-0887271 ☐ 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: PABLO ZERQUERA

Street Address (P.O. Box Number is Not Acceptable): 337-20 ST

Suite, Apt. #, Etc.: 321

City: MIAMI BEACH State: FL Zip Code: 33139

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 (01/05)

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
DPT	PABLO ZERQUERA	3970 SW 67 AVE	MIAMI, FL 33155
DPS	IRENE E. SUAREZ	3970 SW 67 AVE	MIAMI, FL 33155
		REINSTATEMENT 00-05	

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 Irene E. Suarez 8/25/05 (305) 495-8069

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

P.M. MEDICAL CENTER, INC.
3970 SW 67 AVE
MIAMI, FL, 33155

TO:
DIVISION OF CORPORATIONS
P.O.BOX 6327
TALLAHASSEE, FL 32314

Per instructions from the Division of Corporations, I am attaching a Check in the amount of $900.00 for the annual report fee with my application.

We did not receive the U.B.R. for the years 2000, 2001, 2002,2003,2004,2005 or any other notice from the Division of Corporations in respect with the Corporation, P.M. MEDICAL CENTER, INC.

Thank you for your courtesy in this matter.

Irene E Suarez

IRENE E SUAREZ
PRESIDENT