

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

**CORPORATION
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

03 NOV 21 AM 9:15

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P99 000022135

1. Corporation Name

PRIMARY MEDICAL CARE, INC.

2. Principal Office Address

3413 N.W. 17 AVE.

3. Mailing Office Address

3413 N.W. 17 AVE.

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

MIAMI, FL.

City & State

MIAMI, FL.

Zip

33142.

Country

MIAMI-DADE

Zip

33142

Country

MIAMI-DADE.

4. Date Incorporated or Qualified
To Do Business in Florida

3/10/99.

5. FEI Number

650903372

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

FRANCISCO TORRES.

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

3413 N.W. 17 AVE.

Suite, Apt. #, Etc.

City

MIAMI

State

FL

Zip Code

33142.

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

11/17/03

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
PD	PELPE, FAUSTO E.	3413 N.W. 17 AVE	MIAMI, FL. 33142

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)(f), 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 AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

11/18/03

Date

305-635-1614.

Daytime Phone #

CP2E081 (10/02)



3413 N.W. 17 Ave. • Miami, FL 33142 • Ph.: 305-635-1614 • Fax: 305-635-7476

November 12, 2003

Florida Department of State
Division of Corporations
P.O. Box 6327
Tallahassee, Fl. 323143

Re: Corporation of Reinstatement

To Whom It May Concern:

We at Primary Medical Care, Inc., are writing this letter to inform you that we never received a letter of Corporation of Reinstatement this past year, year 2003. Along with this letter I am sending you the application filled out with a check. If you need further information or have any question you can contact me at (305) 635-1614 or (305) 323-9776. I thank you for your time and attention on this matter.

Sincerely,

A handwritten signature in cursive script, appearing to read "Idalys Torres".

Idalys Torres, Office Manager
Primary Medical Care, Inc.