PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

CORPORATION REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

FILED
04 JAN 12 PM 6:24
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P99000036730

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1. Corporation Name
C & L MEDICAL CENTER INC.

REINSTATEMENT 03

2. Principal Office Address	3. Mailing Office Address
12890 N.W. 2nd STREET	12890 N.W. 2nd STREET
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State: MIAMI, FL	City & State: MIAMI, FL
Zip: 33182 Country: MIAMI-DADE	Zip: 33182 Country: MIAMI-DADE

4. Date Incorporated or Qualified To Do Business in Florida

5. FEI Number: 650947055 ☐ 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: LOURDES MARTIN

Street Address (P.O. Box Number is Not Acceptable): 12890 NW 2ND ST

Suite, Apt. #, Etc.:

City: MIAMI State: FL Zip Code: 33182

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: L Martin Date: 1/15/2004

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 Officer and/or Director	City / State / Zip
DP	CARLOS MARTIN	12890 NW 2nd STREET	MIAMI, FL 33182
VPD	LOURDES MARTIN	12890 NW 2nd STREET	MIAMI, FL 33182

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: L Martin 01/05/2004

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

C & L Medical Center, Inc.
12890 NW 2nd Street
Miami, Florida 33182

January 5, 2004

Division of Corporations
Uniform Business Report Filings
P.O. Box 1500
Tallahassee, FL 32302-1500

To Whom It May Concern:

We are sending our 2003 Uniform Business Report Late, because we moved from our previous address and we never received your notification to be able to file it on time.

Please wave your late payment penalty fee this time, since our payment has been unintentionally late.

Thank you for your cooperation in this matter.

Best regards,

Lourdes Martin
Vice-President

Cc: File