PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

CORPORATION REINSTATEMENT

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

APPROVED AND FILED

02 SEP 23 PM 12:16

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

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-10/03/02--01001--010
***1058.75 ***1058.75

DOCUMENT # P99000088010

1. Corporation Name

O'REILLY MEDICAL EQUIPMENT INC.

REINSTATEMENT 2000-2002

2. Principal Office Address	**3.** Mailing Office Address
11117 W	SAME
Suite, Apt. #, etc. OKEECHOBE RD	Suite, Apt. #, etc. #130
City & State HIALEAH GARDENS FL	City & State
Zip 33018 Country USA	Zip Country

4. Date Incorporated or Qualified To Do Business In Florida 10-5-99.

5. FEI Number 65 1007171 ☐ 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: Felix Ricalo

Street Address (P.O. Box Number is Not Acceptable): 11117 W OKEECHOBE RD

Suite, Apt. #, Etc.: #130

City: HIALEAH GARDENS. State: FL Zip Code: 33018

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

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	11117 W OKEECHOBE RD #130	HIALEAH GARDENS	
	Felix Ricalo		FL 33018

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.

X SIGNATURE: _____ Date _____ Daytime Phone # _____

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

OFFICE USE ONLY(DOCUMENT #)

LAZARUS CORPORATE FILING SERVICE

3320 S.W. 87 AVENUE

MIAMI, FLORIDA (305)552-5973

TERESA ROMAN (TALLAHASSEE REPRESENTATIVE)

OFFICE USE ONLY

CORPORATION NAME(S) & DOCUMENT NUMBER(S) (if known):

1. O'REILLY MEDICAL EQUIPMENT INC.
(Corporation Name) (Document #)

2. _____
(Corporation Name) (Document #)

3. _____
(Corporation Name) (Document #)

4. _____
(Corporation Name) (Document #)

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DIVISION OF CORPORATIONS
TALLAHASSEE, FLORIDA

☒ Walk in ☒ Pick up time 2.00 ☐ Certified Copy

☐ Mail out ☐ Will wait ☐ Photocopy ☐ Certificate of Status

	NEW FILINGS
	Profit
	NonProfit
	Limited Liability
	Domestication
	Other

	AMENDMENTS
	Amendment
	Resignation of R.A., Officer/Director
	Change of Registered Agent
	Dissolution/Withdrawal
	Merger

	OTHER FILINGS
	Annual Report
	Fictitious Name
	Name Reservation

	REGISTRATION/ QUALIFICATION
	Foreign
	Limited Partnership
X	Reinstatement
	Trademark
	Other

Examiner's Initials	