PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

(1)

APPLICATION FOR REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Sandra B. Mortham
Secretary of State
DIVISION OF CORPORATIONS

FILED
97 NOV 10 PM 2:01
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # S55978

1. Corporation Name
CARIBBEAN HOSPITAL SUPPLY CORP.

Principal Place of Business	Mailing Address
10112 COSTA DEL SOL BLVD. MIAMI FL 33178	10112 COSTA DEL SOL BLVD. MIAMI FL 33178

If above addresses are incorrect in any way, line through incorrect information and enter correction below.

2. New Principal Office Address, If Applicable	3. New Mailing Office Address, If Applicable
8180 NW 36TH ST.	8180 NW 36TH ST.
Suite, Apt. #, etc.: #310	Suite, Apt. #, etc.: 310
City & State: MIAMI, FL.	City & State: MIAMI, FL.
Zip: 33166 Country:	Zip: 33166 Country:

4. Date Incorporated or Qualified To Do Business in Florida: 05/30/1991

5. FEI Number: 65-0269897 ☐ Applied For ☐ Not Applicable

6. CERTIFICATE OF STATUS DESIRED ☐ $8.75 Additional Fee required for a Certificate of Status

7. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at least 3 directors)

Title(s) 1	Name of Officers and/or Directors 2	Street Address of Each Officer and/or Director (Do NOT Use Post Office Box Numbers) 3	City / State / Zip 4
D	ALI, SUSAN D.	10112 COSTA DEL SOL BLVD	MIAMI FL

100002344931--6
-11/12/97--01088--009
****165.00 ****165.00

10-97

8. Name and Address of Current Registered Agent

BLUTSTEIN, GEORGE J.
#303-20801 BISCAYNE BLVD.
AVENTURA FL 33180

9. Name and Address of New Registered Agent

Name
Street Address (P.O. Box Number is Not Acceptable)
Suite, Apt. #, Etc.
City | State: FL | Zip Code

CR2E040 (8/97)

10. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of Section 607.0505, F.S.

Signature of Registered Agent _____ Date _____
REGISTERED AGENT MUST SIGN

11. This corporation owes or has paid the current year Intangible Personal Property tax due June 30. Yes ☐ No ☐ (See other side for information on intangible tax.)

12. 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: _____ 10/31/97 305-471-0736.
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

CARIBBEAN HOSPITAL SUPPLY CORP.
8181 NW 36TH ST #310
Miami, Fl. 33133
Ph: (305) 471-0736 Fax: (305) 477-0769

October 30 th, 1997

Divisions of Corporations
Annual Report/Reinstatement Section
p. O. Box 6237
Tallahassee Fl. 321314-6327

Dear Sirs,

Re: Caribbean Hospital

This morning I received your notice of Dissolution for the above corporation. I immediately called your office at 850-487-6059 Ext. 2 and explained that honesty I was not aware of it. Your personal mentioned that I had filed in the past and what happened this year.

I went on to explain that I am the one responsible for attending to this and I have had some absences from the office and hence I really did not see any reminders, if they came in I was not made aware of them. I was told to send in my cheque of $165.00 along with this letter for your review and acceptance.

I sincerely apologize for this oversight and promise that it would not happen in the future.

Yours truly,
CARIBBEAN HOSPITAL

Susan Ali.
President.