

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT



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

APPROVED AND FILED
 00 DEC 11 PM 1:46
 SECRETARY OF STATE
 TALLAHASSEE, FLORIDA

DOCUMENT # **V11744**
 1. Corporation Name
GABLES MEDICAL CENTER, INC.

Principal Place of Business Mailing Address
 5200 SW 8 ST PO BOX 55-8908
 STE 150 MIAMI FL 33255-8908
 MIAMI FL 33134-2300
 US



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

2. New Principal Office Address, If Applicable
 Suite, Apt. #, etc.
 City & State
 Zip Country

3. New Mailing Office Address, If Applicable
 Suite, Apt. #, etc.
 City & State
 Zip Country

4. Date Incorporated or Qualified To Do Business in Florida **02/05/1992**

5. FEI Number **65-0310307** 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)	Name of Officers and/or Directors	Street Address of Each Officer and/or Director	City / State / Zip
P	MARIA T. ALVAREZ	3467 SW 199 COURT 216 SW 29TH RD	MIAMI FL 33175 33129 - 2722
VP	HERNANDEZ, MARIA T	3467 SW 199 COURT	MIAMI FL 33175
			800003524058--1 -01/04/01--01104--016 ***758.75 ***758.75
REINSTATEMENT			

8. Name and Address of Current Registered Agent
 ALVAREZ, MARIA T
 3467 SW 199 CT 216 SW 29TH RD.
 MIAMI FL 33175 MIAMI, FL. 33129--2722

9. Name and Address of New Registered Agent
 Name **ALVAREZ Maria T**
 Street Address (P.O. Box Number is Not Acceptable)
216 SW 29TH ROAD
 Suite, Apt. #, Etc.
 City **MIAMI, FL. 33129 - 2722** State **FL** Zip Code

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 *[Signature]* Date **11/14/00**
 REGISTERED AGENT MUST SIGN

11. 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: *[Signature]* 11/14/00 305-448-4800
 SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date Daytime Phone #

CR2E040 (8/00)