

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

**CORPORATION  
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE  
Secretary of State  
DIVISION OF CORPORATIONS

FILED  
05 FEB -4 PM 2: 50  
SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

DOCUMENT # **V56774**

1. Corporation Name  
**TRI MEDIX Management Inc.**

2. Principal Office Address  
**19707 NE 36th Court**

Suite, Apt. #, etc.  
**APT 7H**

City & State  
**Aventura**

Zip **33180** Country **Dade**

3. Mailing Office Address  
**PO Box**

Suite, Apt. #, etc.  
**4081**

City & State **Hallandale Bch**

Zip ~~33008~~ **33008** Country **Broward**

**REINSTATEMENT 03-05**

4. Date Incorporated or Qualified To Do Business in Florida

5. FEI Number **65-0415995**

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 **Michael Weinsreb**  
Street Address (P.O. Box Number is Not Acceptable)  
**19707 NE 36th Court**  
Suite, Apt. #, Etc.  
**# 7H**  
City **Aventura**

State **FL** Zip Code **33180**

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 **Michael Weinsreb**  
REGISTERED AGENT MUST SIGN

Date **2/10/05**

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
<b>owner/principle</b>	<b>Michael Weinsreb</b>	<b>19707 NE 36th Ct Apt 7H</b>	<b>Aventura Fl. 33180</b>

200046419  
02/11/05--01017--009 \*\*450.00

*[Handwritten signature]*

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: **Michael Weinsreb**  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date **2/10/05** Daytime Phone # **305-710-3801**

CR2E081 (01/05)

02-05-2005

TO: FLORIDA DEPARTMENT OF STATE  
DIVISION OF CORPORATIONS

FROM: TRI MEDIX MANAGEMENT INC.  
MICHAEL WEINREB

TO WHOM IT MAY CONCERN,

PLEASE BE ADVISED THAT I NEVER RECEIVED THE ANNUAL  
REPORT DUE TO AN INNCORECT ADDRESS AND THEREFORE  
WAS NOT NOTIFIED PROPERLY TO PAY FOR THE ANNUAL  
FEE.

I HAVE ENCLOSED A REINSTATEMENT FEE FOR \$450.00.  
PLEASE REINSTATE.

THANK YOU,

  
MICHAEL WEINREB - *Principal*  
TRI MEDIX MANAGEMENT INC.  
305-710-3801

*Reinstatement Form Enclosed*