

P100000007607

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

PICK-UP     WAIT     MAIL

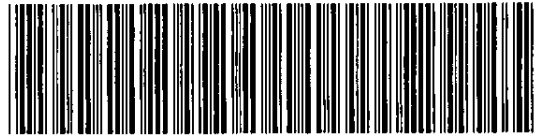
(Business Entity Name)

(Document Number)

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SEP - 4 PM 2:19  
STATE OF MICHIGAN  
FALL RIVER COUNTY REGISTER

SEP 07 2012  
T. ROBERTS

**COVER LETTER**

**TO:** Amendment Section  
Division of Corporations

**SUBJECT:** SEACOAST CLINIC OF CHIROPRACTIC INC.

(Name of Corporation)

**DOCUMENT NUMBER:** P10000007607

The enclosed Officer/Director Resignation for a Corporation and fee are submitted for filing.

Please return all correspondence concerning this matter to the following: -

Leonidas J Demopoulos

(Name of Person)

SEACOAST CLINIC OF CHIROPRACTIC INC.

(Name of Firm/Company)

149 SW Port Saint Lucie Blvd

(Address)

Port Saint Lucie, FL 34984

(City/State and Zip Code)

For further information concerning this matter, please call:

Leonidas J Demopoulos

at ( 772 ) 879-7113

(Name of Person)

(Area Code & Daytime Telephone Number)

Enclosed is a check for \$35.00 made payable to the Florida Department of State.

**Street Address:**

Amendment Section  
Division of Corporations  
Clifton Building  
2661 Executive Center Circle  
Tallahassee, FL 32301

**Mailing Address:**


Amendment Section  
Division of Corporations  
Post Office Box 6327  
Tallahassee, FL 32314

**OFFICER / DIRECTOR RESIGNATION  
FOR A CORPORATION**

I, Leonidas J Demopolos, hereby resign as President  
(Title)

of SEACOAST CLINIC OF CHIROPRACTIC INC.  
(Name of Corporation)

P10000007607, a corporation organized under the laws of the State of  
(Document Number, if known)  
Florida.

  
(Signature of resigning officer/director)

**FILED**  
12 SEP - 4 PM '19  
TALLAHASSEE, FLORIDA

**FILING FEE IS \$35.00**

**Make checks payable to Florida Department of State and mail to:**

Amendment Section  
Division of Corporations  
P.O. Box 6327  
Tallahassee, Florida 32314