

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

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1 of 2

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**CORPORATION
REINSTATEMENT**



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

DOCUMENT #

1. Corporation Name

Holistic chiomed
P97000082100

2. Principal Office Address

499 N.W. Prima Vista Blvd.

Suite, Apt. #, etc.

City & State

Port St. Lucie FL

Zip

34983

Country

USA

3. Mailing Office Address

499 N.W. Prima Vista Blvd.

Suite, Apt. #, etc.

City & State

Port St. Lucie FL

Zip

34983

Country

4. Date Incorporated or Qualified To Do Business in Florida

9-22-97

12-16-97

5. FEI Number

65-0801884

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

Kelly Smith

Street Address (P.O. Box Number is Not Acceptable)

1001 S.W. California Blvd.

Suite, Apt. #, Etc.

City

Port St. Lucie

State

FL

Zip Code

34953

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

Kelly Smith

Date

1-14-02

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
Owner	Kelly Smith	1001 SW California Blvd. Port St. Lucie FL 34953	FL. 34953

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:

Kelly Smith

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

1-14-02

Date

(561) 336-8600

Daytime Phone #

CR2E081 (9/01)

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St. Lucie West Chiropractic

Dr. Kelly L. Smith
499 N.W. Prima Vista Blvd.
Port St. Lucie, FL 34983

Phone (561)336-8600
Fax (561)336-0163

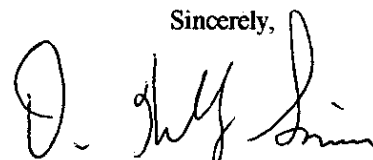
January 14, 2002

To Dept of Corporations

Dear Sir,

I have enclosed a check for 2001 and 2002, as per our conversation. To refresh your memory we have moved our office in 2001 to the address on the included form. Because of the move we did not receive the renewal notice. I hope this will clarify my account. If there is still a problem please inform me so I can take whatever action is needed.

Sincerely,



Dr. Kelly Smith