1 of 2

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

FILED

02 JAN 17 AM 8:56

~~CORPORATION~~
~~REINSTATEMENT~~

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

2001-02
4BR

DOCUMENT #

1. Corporation Name: Holistic chiromed

P97000082100

2. Principal Office Address	**3.** Mailing Office Address
499 N.W. Prima Vista Blvd.	499 N.W. Prima Vista Blvd
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State: Port St. Lucie FL	City & State: Port St. Lucie FL
Zip: 34983 Country: USA	Zip: 34983 Country:

9-22-97

4. Date Incorporated or Qualified To Do Business in Florida: ~~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

900004798809--3
-01/25/02--01076--019
****300.00 ****300.00

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 — REGISTERED AGENT MUST SIGN

Date: 1-14-02

CR2E081 (9/01)

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

Date: 1-14-02

Daytime Phone #: (561) 336-8600

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