

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

1 of 2

FILED

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SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

CORPORATION  
1998 - 2001  
UBR



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

DOCUMENT # # K26518

1. Corporation Name  
ABC CHIROPRACTIC THERAPEUTIC  
WELLNESS INC, JEFFREY S. HOFFMAN DCA

2. Principal Office Address  
3491 WOOLBRIGHT RD

Suite, Apt. #, etc.  
BAY 3

City & State  
BOYNTON BCH, FL

Zip Country  
33436 USA

3. Mailing Office Address  
6542 NEWPORT LK CIR

Suite, Apt. #, etc.

City & State  
BOCARATON FL

Zip Country  
33496 USA

4. Date Incorporated or Qualified To Do Business in Florida  
6/20/88

5. FEI Number  
65-0054809

6. CERTIFICATE OF STATUS DESIRED  \$8.75 Additional Fee required for a Certificate of Status

7. Name and Address of Current Registered Agent

Name RANDIE H. HOFFMAN  
Street Address (P.O. Box Number is Not Acceptable) 3491 WOOLBRIGHT RD BAY 3  
Suite, Apt. #, Etc.  
City BOYNTON BEACH State FL Zip Code 33436

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 [Signature] REGISTERED AGENT MUST SIGN Date 3/28/01

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
PD	JEFFREY S. HOFFMAN	3491 WOOLBRIGHT RD BOYNTON BCH, FL 33436	BOYNTON BCH, FL 33436
Sec	RANDIE H. HOFFMAN	3491 WOOLBRIGHT RD BOYNTON BCH, FL 33436	BOYNTON BCH, FL 33436

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: [Signature] SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR Date 3/28/01 (561) Daytime Phone # 241-7670

CR2E081 (9/00)

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**DR. JEFFREY S. HOFFMAN, D.C., P.A.**

**6542 NEWPORT LAKE CIRCLE  
BOCA RATON, FLORIDA 33496  
PHONE 561736-0000  
Fax 561-8899**

March 28, 2001

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

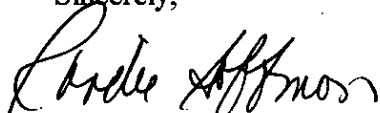
As per our conversation I have enclosed a check for \$600.00 for reinstatement of provider #650054809, ABC Chiropractic Wellness Center. Jeffrey S. Hoffman, D.C., P.A.

As we discussed on the phone I never received a reinstatement notice at the correct mailing address and the \$600.00 dollars should be waived. Please take care of reinstating this as soon as possible.

The correct mailing address is 6542 Newport Lake Circle, Boca Raton, Florida 33496. The office address is 3491 Woolbright Road, Boynton Beach, Florida 33436.

Thank you for your cooperation in this matter.

Sincerely,



Randie Hoffman

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