PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Sandra B. Mortham
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # 604464

1. Corporation Name

WEBB CHIROPRACTIC CLINIC, P.A.

[redacted]

Principal Place of Business	Mailing Address
787 E. PRIMA VISTA BLVD. PORT ST. LUCIE FL 34952-2274	787 E. PRIMA VISTA BLVD. PORT ST. LUCIE FL 34952-2274

If above addresses are incorrect in any way, line through incorrect information and enter correction below

2. New Principal Office Address, If Applicable
Suite, Apt. #, etc
City & State
Zip / Country

3. New Mailing Office Address, If Applicable
Suite, Apt. #, etc
City & State
Zip / Country

4. Date Incorporated or Qualified To Do Business in Florida: 06/25/1973

5. FEI Number: 59-1483162 — Applied For / Not Applicable

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

7. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at least 3 directors)

1 Title(s)	2 Name of Officers and/or Directors	3 Street Address of Each Officer and/or Director (Do NOT Use Post Office Box Numbers)	4 City / State / Zip
PD	WEBB, JACK	787 E. PRIMA VISTA BLVD	PT ST LUCIE FL

REINSTATEMENT 98-99 B 5/5/99

200002866067--9
-05/07/99--01131--006
****800.00 ****800.00

8. Name and Address of Current Registered Agent

SCHAFFER, H.
2765 CARDINAL CIRCLE
GULF STREAM FL 33483

9. Name and Address of New Registered Agent

Name: Jack Webb
Street Address (P.O. Box Number is Not Acceptable): 787 E. Prima Vista Blvd
Suite, Apt. #, Etc
City: Port St. Lucie State: FL Zip Code: 34952

10. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of Section 607.0505, F.S.

Signature of Registered Agent: X [signature] Date: 4/27/99
REGISTERED AGENT MUST SIGN

11. This corporation owes or has paid the current year Intangible Personal Property tax due June 30. Yes ☑ No ☐ (See other side for information on intangible tax.)

12. 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: X [signature] 4/27/99 561-878-3773
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #