

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

**APPLICATION
FOR
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE
DIVISION OF CORPORATIONS

APPROVED
AND
FILED

1997 AUG 14 PM 1:16

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # G58554

1. Corporation Name

CHIROPRACTIC BACK PAIN CLINIC INC.

Mailing Address

**2601 Douglas Road
Suite 802
Miami, FL 33133**

Principal Place of Business

**2601 Douglas Road
Suite 802
Miami, FL 33133**

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

2. New Mailing Address, If Applicable

3. New Principal Office Address, If Applicable

4. Date Incorporated or Qualified
To Do Business in Florida

09/02/1983

Suite, Apt. #, etc.

Suite, Apt. #, etc.

5. FEI Number

59-2324477

Applied For

Not Applicable

City & State

City & State

Zip

Country

Zip

Country

6. CERTIFICATE OF STATUS DESIRED ☐

**\$9.75 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
P/S/D	OCTAVIO P. FERNANDEZ, D.C.	2601 DOUGLAS ROAD SUITE #802	MIAMI, FL 33133
			700002269027--8 -08/15/97--01118--008 ****915.00 ****915.00

REINSTATEMENT

8. Name and Address of Current Registered Agent

**OCTAVIO P. FERNANDEZ, D.C.
2601 Douglas Road
Suite 802
Miami, FL 33133**

9. Name and Address of New Registered Agent

Name

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

Suite, Apt. #, Etc.

City

State
FL

Zip Code

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]
REGISTERED AGENT MUST SIGN

Date **JUL 08 1997**

11. If this corporation is a non-profit with I.R.S. 501(c)(3) tax exempt status, check this box ☐ (See other side for additional information.)

12. Does this corporation pay any intangible tax to the
Dept. of Revenue under S. 199.032, Florida Statutes. Yes ☒ No ☐ (See other side for information on intangible tax.)

13. I do hereby certify that the information supplied with this filing is voluntarily furnished and does not qualify for the exemption stated in Section 119.07(3)(k), Florida Statutes. I release the Division of Corporations from any liability of non-compliance with Section 119.07(3)(k) in the event that the information supplied is deemed exempt from public access. 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., and that all fees owed by the corporation have been paid. 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 AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

JUL 08 1997

X (805)774-0277

CR2E040 (6/94)