PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM

FILED
03 DEC 11 AM 11:39
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

CORPORATION REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # G70106

1. Corporation Name
WELSH CLINIC OF CHIROPRACTIC, PA

741030600034999

59-2439498

000024698640
11/14/03--0101--012 **500.00

REINSTATEMENT DO-03

2. Principal Office Address	3. Mailing Office Address
5121 EHRLICH Rd	SAME
Suite, Apt. #, etc.: SUITE 109	Suite, Apt. #, etc.
City & State: TAMPA FL	City & State
Zip: 33624 Country: USA	Zip Country

4. Date Incorporated or Qualified To Do Business in Florida: 11-15-1983

5. FEI Number: (G70106) ☐ 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: SUSAN WELSH

Street Address (P.O. Box Number is Not Acceptable): 5121 EHRLICH Rd

Suite, Apt. #, Etc.: SUITE 109

City: TAMPA State: FL Zip Code: 33624

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: Susan Welsh — REGISTERED AGENT MUST SIGN — Date: 11/03/03

CR2E081 (10/02)

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
PRES.	SUSAN WELSH	5121 EHRLICH Rd #109	TAMPA, FL. 33624
V PRES	THOMAS E. MARTIN	9401 HANLON DR	ODESSA, FL. 33556

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: Susan Welsh — SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date: 11/03/03 — Daytime Phone #: (813) 962-2489

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SPORTS INJURY & NUTRITION CENTER

WELSH CLINIC OF CHIROPRACTIC, P.A.

SUSAN WELSH, D.C., D.A.C.B.S.P.
Certified Chiropractic Sports Physician
Diplomate American Chiropractic Board of Sports Physicians

LYNETTE BERVEN, D.C.
Chiropractic Physician

NEAL SAYERS, D.C.
Chiropractic Physician

5121 Ehrlich Road, Suite 109
Tampa, FL 33624
(813) 962-2489 Office
(813) 962-8781 Fax
www.welshclinic.com

October 28, 2003

Department of State
Division of Corporations
P.O. Box 6327
Tallahassee, FL 32314

TO WHOM IT MAY CONCERN:

RE: WELSH CLINIC OF CHIROPRACTIC, PA

It has come to my attention that you have an incorrect address in your system for my office which resulted in the dissolution of my corporation due to non-payment of fees. As our office never received any of the notices for payment due to this error, I am requesting a waiver of the reinstatement fee of $600 for our corporation. We are also requesting that a correction to your data base be made for our address which is as follows:

Welsh Clinic of Chiropractic, P.A.
5121 Ehrlich Road, Suite 109
Tampa, FL 33624

I am enclosing a check for $600 for the balance of our fees to update my account. Thank you for your assistance with this matter.

Sincerely,

Susan Welsh

Susan Welsh, D.C.
President

SW/sjw