


PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM

LIMITED LIABILITY COMPANY REINSTATEMENT 2016		 FLORIDA DEPARTMENT OF STATE Secretary of State DIVISION OF CORPORATIONS	
DOCUMENT # <u>L15000194049</u>			
1. Limited Liability Company's Name <u>Columbia County Chiropractic Center, LLC</u>			
2. Principal Office Address - No P.O. Box # <u>279 SW Main Blvd.</u> Suite, Apt. #, etc. <u>-</u>		3. Mailing Office Address <u>279 SW Main Blvd.</u> Suite, Apt. #, etc. <u>-</u>	
City & State <u>Lake City, FL</u>		City & State <u>Lake City, FL</u>	
Zip <u>32025</u>	Country <u>USA</u>	Zip <u>32025</u>	Country <u>USA</u>
4. State/Country of Formation <u>Florida / Columbia</u>			
5. Date Organized or Qualified To Do Business in Florida <u>11-09-15</u>			
6. FEI Number <u>592976336</u>		Applied For <input type="checkbox"/> Not Applicable	
7. CERTIFICATE OF STATUS DESIRED <input checked="" type="checkbox"/> \$5.00 Additional Fee required for a certificate of status			
8. Name and Address of Current Registered Agent Name <u>Guy W. Norris</u> Street Address (P.O. Box Number is Not Acceptable) Suite, Apt. #, Etc. <u>253 NW Main Blvd</u> City <u>Lake City</u> State <u>FL</u> Zip Code <u>32055</u>			
9. I, being appointed the registered agent of the above named limited liability company, am familiar with and accept the obligations of Chapter 605, F.S. Signature of Registered Agent <u>[Signature]</u> Date <u>10-13-16</u> REGISTERED AGENT MUST SIGN			
10. Names and Street Addresses of Authorized Representatives/Managers			
Titles	Name of Authorized Representatives/Managers	Street Address of Each Authorized Representative/Manager	City / State / Zip
<u>AR owner</u>	<u>Darrel T. Mathis, D.C., F.A.C.O.</u>	<u>279 SW Main Blvd.</u>	<u>Lake City, FL 32025</u>
<u>AR</u>	<u>Mary Kay Mathis</u>	<u>179 NW Otter Ct</u>	<u>Lake City, FL 32055</u>
11. E-mail Address: <u>ccchiromgr@gmail.com</u> (To be used for future annual report notifications)			
12. I certify that I am an authorized representative/manager or the receiver or trustee empowered to execute this application as provided for in Chapter 605, F.S. I further certify that when filing this reinstatement application the reason for dissolution has been eliminated, the limited liability company name satisfies the requirement of section 605.0012, F.S., and that all fees owed by the limited liability company 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. I am aware that false information submitted in a document to the Department of State constitutes a third degree felony as provided for in s. 817.155, F.S. Signature of authorized representative/member <u>[Signature]</u> Date <u>10-13-16</u> Daytime Phone # <u>(386) 752-4313</u> Typed or printed name of signing authorized representative/member <u>Darrel T. Mathis, D.C., F.A.C.O.</u>			

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STATE OF FLORIDA
TALLAHASSEE, FLORIDA

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