PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT 02WBR

FLORIDA DEPARTMENT OF STATE
Jim Smith
Secretary of State
DIVISION OF CORPORATIONS

FILED
02 OCT 25 PM 12:38
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # **P00000115932**

1. Corporation Name

OPTIMAL HEALTH, INC.

Principal Place of Business	Mailing Address
1540 N TRAFALGAR CIR HOLLYWOOD FL 33020	1540 N TRAFALGAR CIR HOLLYWOOD FL 33020

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

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

4. Date Incorporated or Qualified To Do Business in Florida: 01/01/2001

5. FEI Number: 65-1066052 ☐ 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)

Title(s) 1	Name of Officers and/or Directors 2	Street Address of Each Officer and/or Director 3	City / State / Zip 4
DP	MCKENZIE, KANDIS R	1540 N TRAFALGAR CIR	HOLLYWOOD FL 33020

500008599965
10/25/02--01108--019 **150.00

AR 10/30

8. Name and Address of Current Registered Agent

MCKENZIE, KANDIS R
1540 N TRAFALGAR CIR
HOLLYWOOD FL 33020

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

CR2E040 (8/02)

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. or 617.0505, F.S.

Signature of Registered Agent: SIGNATURE REQUIRED — Date: 10/22/02

REGISTERED AGENT MUST SIGN

11. 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 REQUIRED (954) 925-2899 — Date: 10/22/02

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

10/22/02

To Whom it May Concern:

I did not receive the UBR notices regarding my corporation Optimal Health, Inc. Since I run my business out of my home and the corporation name does not match my personal name, I have occasionally not received all of the mail intended for Optimal Health, Inc. Please accept my completed application for reinstatement and the $150.00 UBR filing fee. Thank you for your attention to this matter.

Sincerely,

Kandis McKenzie, Director
Optimal Health, Inc.