

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION

REINSTATEMENT



FLORIDA DEPARTMENT OF STATE

Jim Smith

Secretary of State

DIVISION OF CORPORATIONS

DOCUMENT # P00000115932

1. Corporation Name

OPTIMAL HEALTH, INC.

Principal Place of Business

1540 N TRAFALGAR CIR
HOLLYWOOD FL 33020

Mailing Address

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

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

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)

Name of Officers
and/or Directors

Street Address of Each
Officer and/or Director

City / State / Zip

DP

MCKENZIE, KANDIS R

1540 N TRAFALGAR CIR

HOLLYWOOD FL 33020

5000008599965

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

DR 10/30

8. Name and Address of Current Registered Agent

9. Name and Address of New Registered Agent

MCKENZIE, KANDIS R
1540 N TRAFALGAR CIR
HOLLYWOOD FL 33020

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. or 617.0505, F.S.

Signature of
Registered Agent

SIGNATURE REQUIRED

REGISTERED AGENT MUST SIGN

Date

10 / 22 / 02

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

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

10 / 22 / 02

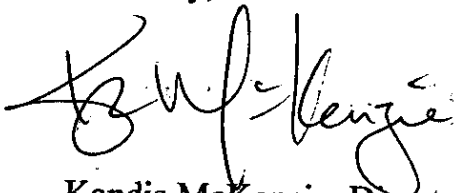
CR2E040 (8/02)

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,

A handwritten signature in cursive script, appearing to read "Kandis McKenzie".

Kandis McKenzie, Director
Optimal Health, Inc.