PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

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CORPORATION REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

FILED
06 OCT 16 PM 1:42
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

06

800080038538

CR2E081 (12/06)

DOCUMENT # P01000080871

1. Corporation Name

SIMPSON CHIROPRACTIC PAIN AND WELLNESS CENTER, P.A.

2. Principal Office Address	3. Mailing Office Address
104 S.E. Lonita Street	" "
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State: Stuart, FL	City & State
Zip: 34994 County: Martin	Zip / Country

4. Date Incorporated or Qualified To Do Business in Florida

5. FEI Number: 651182786 ☐ 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: CORPORATION SERVICE COMPANY

Street Address: 1201 HAYS STREET

Suite, Apt. #, Etc.:

City: TALLAHASSEE State: FL Zip Code: 32301

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: Dina L. Davis Dina L. Davis as its agent Date: 10-13-06

REGISTERED AGENT MUST SIGN

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
D	Charles A. Simpson	508-A S.W. California Ave.	Stuart, FL 34994
D	Melinda C. Simpson	508-A S.W. California Ave.	Stuart, FL 34994

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 contained in Chapter 119, 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.

(772)

SIGNATURE: Melinda C. Simpson 10.5-2006 463.2344

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

CORPORATION SERVICE COMPANY®

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ACCOUNT NO. : 072100000032

REFERENCE : 483154 7281331

AUTHORIZATION

COST LIMIT : $ 750.00

ORDER DATE : September 27, 2006

ORDER TIME : 2:08 PM

ORDER NO. : 483154-015

CUSTOMER NO: 7281331

RECEIVED
06 OCT 16 AM 8:43
[illegible]

DOMESTIC FILINGS

NAME: SIMPSON CHIROPRACTIC PAIN AND WELLNESS CENTER, P.A.

XX ___ REINSTATEMENT

PLEASE RETURN THE FOLLOWING AS PROOF OF FILING:

XX _____ PLAIN STAMPED COPY

CONTACT PERSON: Dina Davis-Ext# 2910 Thank you!

EXAMINER'S INITIALS _____