

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION
FOR
REINSTATEMENT



FLORIDA DEPARTMENT OF STATE
Glenda E. Hood
Secretary of State
DIVISION OF CORPORATIONS

FILED

03 OCT 15 AM 8:31

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P01000112771

1. Corporation Name

CHIROMED HEALTH ALLIANCE, INC.

Principal Place of Business

24 NE 24TH AVENUE
POMPANO BEACH FL 33062

Mailing Address

24 NE 24TH AVENUE
POMPANO BEACH FL 33062

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

11/28/2001

5. FEI Number

27-0001141

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
P	DIGIORGIO, NATHALIE M DC	24 NE 24TH AVENUE	POMPANO BEACH FL 33062
V	DIGIORGIO, THOMAS H JR.	24 NE 24TH AVENUE	POMPANO BEACH FL 33062

600023806776
10/15/03--01025--007 **150.00

8. Name and Address of Current Registered Agent

DIGIORGIO, NATHALIE M DC
24 NE 24TH AVENUE
POMPANO BEACH FL 33062

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

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 10-10-03

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
DIGIORGIO, Nathalie M DC
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

10-10-03 954 941-3866

CR2E040 (7/03)

CHIROMED HEALTH ALLIANCE, INC

Department of State
Division of Corporations
409 East Gaines St.
Tallahassee, FL 32399

10-10-2003

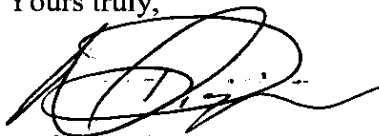
To whom it may concern,

This letter is to notify you that I **did not receive** any prior (UBR) notices. This is my first year in this corporate complex and sometimes my mail ends up within someone else's mailbox. Therefore I am asking that the **reinstatement fee be waived**.

I do apologize for any inconvenience this may have caused. I am sending the application for re-instatement via registered mail with check # 1193 in the amount of **\$150.00**.

Thank you for your understanding,

Yours truly,



Nathalie DiGiorgio, D.C., President
Chiromed Health Alliance, Inc.
FEI # 27-0001141