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	Mailing Address
24 NE 24TH AVENUE POMPANO BEACH FL 33062	24 NE 24TH AVENUE POMPANO BEACH FL 33062

REINSTATEMENT 03

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	9. Name and Address of New Registered Agent
DIGIORGIO, NATHALIE M DC 24 NE 24TH AVENUE POMPANO BEACH FL 33062	Name Street Address (P.O. Box Number is Not Acceptable) Suite, Apt. #, Etc. City / State: FL / Zip Code

CR2E040 (7/03)

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 10-10-03
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 DiGiorgio, Nathalie M DC 10-10-03 954 941-3866
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

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

24 NE 24TH AVENUE • POMPANO BEACH, FL • 33062
PHONE: 954-941-3866 • FAX: 954-943-7708