

# **2014 FOR PROFIT CORPORATION REINSTATEMENT**

DOCUMENT# P10000096863

**FILED**  
**Oct 07, 2014**  
**Secretary of State**

**Entity Name:** DOCTORS BEST WELLNESS CENTERS INC.

**Current Principal Place of Business:**

5542 SOUTH FLAMINGO ROAD  
COOPER CITY, FL 33330

**New Principal Place of Business:**

**Current Mailing Address:**

5542 SOUTH FLAMINGO ROAD  
COOPER CITY, FL 33330

**New Mailing Address:**

**FEI Number:** 27-4185066

**FEI Number Applied For ( )**

**FEI Number Not Applicable ( )**

**Certificate of Status Desired ( )**

**Name and Address of Current Registered Agent:**

SPIEGEL & UTRERA, P.A.  
1840 SW 22ND ST.  
4TH FLOOR  
MIAMI, FL 33145 US

**Name and Address of New Registered Agent:**

The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida.

**SIGNATURE:** VAL MANOCCHIO MD

\_\_\_\_\_  
Electronic Signature of Registered Agent

\_\_\_\_\_  
Date

**OFFICERS AND DIRECTORS:**

**Title:** PD  
**Name:** MANOCCHIO, VAL M.D.  
**Address:** 5542 SOUTH FLAMINGO ROAD  
**City-St-Zip:** COOPER CITY, FL 33330

**Title:** STD  
**Name:** MANOCCHIO, RACHAEL  
**Address:** 5542 SOUTH FLAMINGO ROAD  
**City-St-Zip:** COOPER CITY, FL 33330

I hereby certify that the information indicated on this report or supplemental report is true and accurate and that my electronic signature shall have the same legal effect as if made under oath; that I am an officer or director of the corporation or the receiver or trustee empowered to execute this report as required by Chapter 607, Florida Statutes; and that my name appears above, or on an attachment with all other like empowered.

**SIGNATURE:** VAL MANOCCHIO MD

\_\_\_\_\_  
Electronic Signature of Signing Officer or Director

PD

10/07/2014

\_\_\_\_\_  
Date