

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 24 PM 12:29

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

DOCUMENT # **P92000000753**

1. Corporation Name

**PINE PLAZA CHIROPRACTIC CENTER, INC.**

Principal Place of Business

Mailing Address

7195 W. OAKLAND PARK BLVD.  
LAUDERHILL FL 33313  
US

7195 W. OAKLAND PARK BLVD.  
LAUDERHILL FL 33313  
US

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

REINSTATEMENT

03



500024075215  
10/24/03--01017--028 \*\*150.00

4. Date Incorporated or Qualified  
To Do Business in Florida

11/01/1992

5. FEI Number

65-0378659

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
PD	SCHWARTZ, MICHAEL	1573 NE 37TH ST	FORT LAUDERDALE FL 33334

8. Name and Address of Current Registered Agent

SCHWARTZ, MICHAEL DR  
1573 NE 37TH ST  
FT LAUDERDALE FL 33334

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

*DR Michael D Schwartz*  
REGISTERED AGENT MUST SIGN

Date 10-15-2003

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: *DR Michael D Schwartz*  
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

10-15-2003 954 742-5265

Date

Daytime Phone #

CR2E040 (7/03)



Dr. Michael D. Schwartz

Chiropractic Physician



To Whom It May Concern:

I did not receive the UBP for this year, nor did I receive a reminder notice. This has never happened before - Enclosed is our check for 150.00 to reinstate per my conversation with your representative the other day. If further information is required, I can be contacted at

954-742-5265

Thank you -

Dr. Michael D. Schwartz