PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Jim Smith
Secretary of State
DIVISION OF CORPORATIONS

FILED
02 OCT 30 AM 11:36
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P93000010812

1. Corporation Name

MICHAELS CHIROPRACTIC SPORTS MEDICINE CENTER, P. A.

Principal Place of Business	Mailing Address
5A SANCHEZ AVE ST AUGUSTINE FL 32084 US	5A SANCHEZ AVE ST AUGUSTINE FL 32084 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

4. Date Incorporated or Qualified To Do Business in Florida: 02/12/1993

5. FEI Number: 65-0392354 ☐ 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
D	MICHAELS, SCOTT	5A SANCHEZ AVE	ST AUGUSTINE FL

700008696887
10/30/02--01044--021 **150.00

8. Name and Address of Current Registered Agent	9. Name and Address of New Registered Agent
MICHAELS, SCOTT 5A SANCHEZ AVE ST AUGUSTINE FL 32084	Name Street Address (P.O. Box Number is Not Acceptable) Suite, Apt. #, Etc. City / State: FL / Zip Code

CR2E040 (8/02)

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: 10-21-02

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 — 10-21-02 — 904 823 8833

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

Michaels Chiropractic Sports Medicine Center
DR. SCOTT MICHAELS
CHIROPRACTIC PHYSICIAN

☎ **Telephone** (904)823-8833
✉ **Email** drsmichaels@worldnet.att.net

5A Sanchez Avenue
St. Augustine, FL 32084

Florida Department of State
Division of Corporations
P.O. Box 6327
Tallahassee FL 32314

10/21/02

Dears Sirs,
This is to confirm that I had not received any notifications previously nor appropriate paper work to file the annual corporate business report for Michaels Chiropractic Sports Medicine Center PA . Enclosed is a check for 150.00 for the regular annual fee.
Thank you for your cooperation with respect to this matter

Sincerely,

Dr. Scott Michaels