PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT

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

FILED
03 JAN -3 AM 9:07
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P93000018955

1. Corporation Name

ASSOCIATED CHIROPRACTIC PHYSICIANS, INC.

Principal Place of Business	Mailing Address
2573 NORTH KINGS ROAD P.O. BOX 1678 HILLIARD FL 32046 US	PO BOX 1678 HILLIARD FL 32046

If above addresses are incorrect in any way, line through incorrect information and enter correction below.

REINSTATEMENT 02

2. New Principal Office Address, If Applicable	3. New Mailing Office Address, If Applicable
54 1675 US Hwy #1	SAME
Suite, Apt. #, etc.	Suite, Apt. #, etc.
City & State: Hilliard, Fl.	City & State
Zip: 32046 Country: NASSAU	Zip Country

4. Date Incorporated or Qualified To Do Business in Florida: 03/08/1993

5. FEI Number: 59-3169023 ☐ 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)

1 Title(s)	2 Name of Officers and/or Directors	3 Street Address of Each Officer and/or Director	4 City / State / Zip
P	KORNACKI, KERRY	RT 4 BOX 7379	HILLIARD FL 32046
M	KORNACKI, DEBRA	RT 4 BIX 7379	HILLIARD FL 32046
		600009822016 01/03/03--01094--003 **750.00	

8. Name and Address of Current Registered Agent

KORNACKI, KERRY E
2573 NORTH KINGS ROAD
POST OFFICE BOX 1678
HIALLIARD FL 32046

9. Name and Address of New Registered Agent

Name: KORNACKI, Kerry E.
Street Address (P.O. Box Number is Not Acceptable): 54 1675 U.S. Hwy #1
Suite, Apt. #, Etc.: P.O. Box 1678
City: Hilliard State: FL Zip Code: 32046

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.

Dr. Kerry E. Kornacki
Signature of Registered Agent: SIGNATURE REQUIRED
REGISTERED AGENT MUST SIGN
Date: 11-12-02

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.

DEBRA A. KORNACKI
SIGNATURE: SIGNATURE REQUIRED
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR
Date: 11-1-02
Daytime Phone #