

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

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96-97 AR  
REINSTATEMENT  
DIVISION OF CORPORATIONS

FILED

97 JUN 23 AM 8:51

SECRETARY OF STATE  
TALLAHASSEE FLORIDA

DOCUMENT # P95000075427

1. Corporation Name  
**THE WELLNESS COUNSELING CENTER, INC.**

Principal Place of Business  
506 BONNIE BRAE WAY  
HOLLYWOOD FL 33021

Mailing Address  
506 BONNIE BRAE WAY  
HOLLYWOOD FL 33021



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		4. Date Incorporated or Qualified To Do Business in Florida	
Suite, Apt. #, etc.		Suite, Apt. #, etc.		10/02/1995	
City & State		City & State		5. FEI Number	
Zip		Zip		65-061 8884	
Country		Country		Applied For	
				Not Applicable	
				6. CERTIFICATE OF STATUS DESIRED <input type="checkbox"/> \$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)	Name of Officers and/or Directors	Street Address of Each Officer and/or Director (Do NOT Use Post Office Box Numbers)	City / State / Zip
1	2	3	4
D	SAVITS, ELLEN	506 BONNIE BRAE WAY	HOLLYWOOD FL 33021

300002224499--1  
-06/27/97-01017-004  
\*\*\*\*365.00 \*\*\*\*365.00

8. Name and Address of Current Registered Agent		9. Name and Address of New Registered Agent	
COHN, LOUIS J ESQ. 4309 N. UNIVERSITY DRIVE, SUITE B-104 LAUDERHILL FL 33351		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.

Signature of Registered Agent *Louis J Cohn* Date 5/21/97

REGISTERED AGENT MUST SIGN

11. Does this corporation pay any intangible tax to the Dept. of Revenue under S. 199.032, Florida Statutes. Yes ☐ No ☐ (See other side for information on intangible tax.)

12. I certify that I am an officer or director or the recolver 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: *Ellen Savits* Date 5/21/97 Daytime Phone # 954 7961407

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

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Dr. Myer F. Savits

506 Bonnie Brae Way, Hollywood, Florida 33021 (954) 985-0866

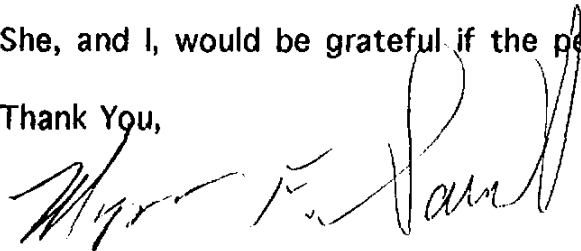
June 12, 1997

Ellen has been completely disabled for the past two and one half years and is now receiving full disability pension from Social Security. (See copy of her medicare card).

During the past eighteen months, she has been hospitalized three times (Northshore Hospital in Chicago) for no less than three weeks each time. In spite of these problems, she will probably recover enough to return to her profession and it is extremely important that she not lose the corporation.

She, and I, would be grateful if the penalty could be waived.

Thank You,

A handwritten signature in cursive script, appearing to read "Myer F. Savits", written in dark ink.

Dr. Myer F. Savits