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 25 PM 1:43
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # P96000041988

1. Corporation Name

**ACCESS HEALTH CENTER, INC.**

| Principal Place of Business | Mailing Address |
|---|---|
| 795 NW CRESTVIEW CIRCLE<br>PORT CHARLOTTE FL 33948 | 795 NW CRESTVIEW CIRCLE<br>PORT CHARLOTTE FL 33948 |

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: 05/15/1996

5. FEI Number: 65-0680701 ☐ 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 | WINSOR, DAVID M D.C. | 795 NW CRESTVIEW CIRCLE | PORT CHARLOTTE FL 33948 |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

700008581457
10/25/02--01008--006 **150.00

| 8. Name and Address of Current Registered Agent | 9. Name and Address of New Registered Agent |
|---|---|
| WINSOR, DAVID M D.C.<br>795 NW CRESTVIEW CIRCLE<br>PORT CHARLOTTE FL 33948 | Name<br>Street Address (P.O. Box Number is Not Acceptable)<br>Suite, Apt. #, Etc.<br>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:
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 DAVID M. WINSOR — 10/22/02 — 941-624-8444
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

Access Health Center
795 NW Crestview Circle
Port Charlotte, FL 33948
Tel. (941) 629-8444
Fax (941) 629-9513

David M. Winsor, D.C.

Denise E. Orazi, D.C.

October 22, 2002

Florida Department of State,
Division of Corporations,
Annual Report/Reinstatement Section,
PO Box 6327
Tallahassee FL 32314-6327

Dear Sirs,

Doc# P96000041988 FEI# 65-0680701

We have today received a Notice of Administrative Dissolution or Revocation. This is the first notice we have received and certify that we did not receive either a first or second notice earlier in the year. We therefore enclose the completed Application for Reinstatement with our cheque for $150.00.

We thank you for your help in this matter.

Yours sincerely,

Dr David M Winsor
President Access Health Center, Inc.