

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION



FLORIDA DEPARTMENT OF STATE

Jim Smith

Secretary of State

DIVISION OF CORPORATIONS

REINSTATEMENT

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

795 NW CRESTVIEW CIRCLE
PORT CHARLOTTE FL 33948

Mailing Address

795 NW CRESTVIEW CIRCLE
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

Suite, Apt. #, etc.

City & State

Zip

Country

3. New Mailing Office Address, If Applicable

Suite, Apt. #, etc.

City & State

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

10/22

8. Name and Address of Current Registered Agent

WINSOR, DAVID M D.C.
795 NW CRESTVIEW CIRCLE
PORT CHARLOTTE FL 33948

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

CR2ED40 (802)

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
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

10/22/02

941-624-8444
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

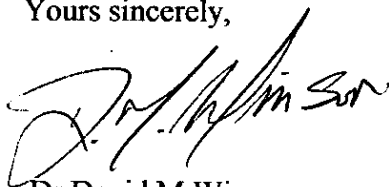
Dear Sirs,

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,

A handwritten signature in black ink, appearing to read "Dr. David M. Winsor", written in a cursive style.

Dr David M Winsor
President Access Health Center, Inc.