

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

**APPLICATION
FOR
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE
Katharine Harris
Secretary of State
DIVISION OF CORPORATIONS

FILED

01 MAR 12 AM 9:26

SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # **P98000025763**

1. Corporation Name

CHIROPRACTIC INJURY & TRAUMA CENTERS, INC.

Principal Place of Business

600 W OAKRIDGE RD
ORLANDO FL 32809

Mailing Address

600 W OAKRIDGE RD
ORLANDO FL 32809

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

03/18/1998

5. FEI Number

59-3497913

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	CAFIERO, ANTHONY	600 W OAKRIDGE RD	ORLANDO FL 32809
P	ENRIQUE HERNANDEZ	811 W OAKRIDGE RD.	ORLANDO FL 32809

8. Name and Address of Current Registered Agent

CAFIERO, ANTHONY
600 W OAKRIDGE RD
ORLANDO FL 32809

9. Name and Address of New Registered Agent

Name

HERNANDEZ, ENRIQUE

Street Address (P.O. Box Number is Not Acceptable)

811 W OAKRIDGE RD.

Suite, Apt. #, Etc.

City

ORLANDO

State

FL

Zip Code

32809

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

[Signature]
SIGNATURE REQUIRED
REGISTERED AGENT MUST SIGN

Date **2/15/2001**

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]
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

2/15/2001

Date

407-858-0604

Daytime Phone #

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Chiropractic Injury & Trauma Center

811 W. Oakridge Road

Orlando, FL 32809

March 8, 2001

Florida Department of State

Katherine Harris

Secretary of State

Division of Corporations

P.O. Box 6327

Tallahassee, FL 32314

Subject: Chiropractic Injury & Trauma Center

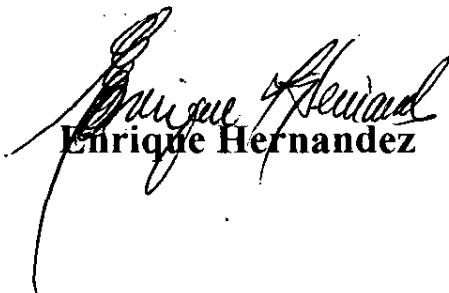
Ref. Number: P98000025763

Letter Number: 401A00012271

In response to the above mentioned letter number, please be advised that Chiropractic Injury & Trauma Center never received the filing fee document.

I would greatly be appreciated if the late fee would be waived.

Respectfully,


Enrique Hernandez