PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

~~APPLICATION FOR REINSTATEMENT~~

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

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P98000025763

FILED
01 MAR 12 AM 9:26
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

SP

DOCUMENT # P98000025763

1. Corporation Name

CHIROPRACTIC INJURY & TRAUMA CENTERS, INC.

Principal Place of Business	Mailing Address
600 W OAKRIDGE RD ORLANDO FL 32809	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		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: 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 ~~600~~ W OAKRIDGE RD.	ORLANDO FL 32809
			800003887738--9 -03/20/01--01029--004 ****300.00 ****300.00

8. Name and Address of Current Registered Agent	9. Name and Address of New Registered Agent
CAFIERO, ANTHONY 600 W OAKRIDGE RD ORLANDO FL 32809	Name: HERNANDEZ, ENRIQUE Street Address (P.O. Box Number is Not Acceptable): 811 ~~600~~ W OAKRIDGE RD. Suite, Apt. #, Etc.: City: ORLANDO State: FL Zip Code: 32809

CR2E040(8/00)

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 X SIGNATURE REQUIRED Date 2/15/2001

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: X SIGNATURE REQUIRED Enrique Hernandez 2/15/2001 407-858-0604

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

Pg 2 of 2

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