PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Glenda E. Hood
Secretary of State
DIVISION OF CORPORATIONS

FILED
03 OCT 15 AM 9:08
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DOCUMENT # **P99000042132**

1. Corporation Name

SHERYL ANNE CAMMENGA MASSAGE THERAPY, INC.

Principal Place of Business	Mailing Address
4803 BUCHANAN DR FORT PIERCE FL 34982 US	4803 BUCHANAN DR FORT PIERCE FL 34982 US

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: 05/05/1999

5. FEI Number: 65-0909754 ☐ 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
P	CAMMENGA, SHERYL ANN	4803 BUCHANAN DRIVE	FORT PIERCE FL 34982

400023802324
10/15/03--01016--009 **150.00

8. Name and Address of Current Registered Agent	9. Name and Address of New Registered Agent
CAMMENGA, SHERYL ANN 4803 BUCHANAN DRIVE FORT PIERCE FL 34982	Name Street Address (P.O. Box Number is Not Acceptable) Suite, Apt. #, Etc. City / State: FL / Zip Code

CR2E040 (7/03)

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 Sheryl Anne Cammenga — Date: 10-9-03
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.

President

SIGNATURE: SIGNATURE Sheryl Anne Cammenga — Sheryl Anne Cammenga — 10-09-03 — 7724672674
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

SHERYL ANNE CAMMENGA MASSAGE THERAPY, INC.
4803 BUCHANAN DRIVE
FORT PIERCE, FLORIDA 34982

OCTOBER 9, 2003

FLORIDA DEPARTMENT OF STATE
GLENDA E. HOOD
SECRETARY OF STATE
DIVISION OF CORPORATIONS
P.O BOX 6327
TALLAHASSEE, FLORIDA 32314-6327

DEAR GLENDA E. HOOD:

ENCLOSED YOU WILL FIND APPLICATION FOR REINSTATEMENT, DOCUMENT # P99000042132 FOR THE ABOVE NAMED CORPORATION.

I AM ASKING FOR A WAIVER OF THE REINSTATEMENT FEE OF $600.00 BECAUSE OF THE FOLLOWING.

THE FIRM DOING MY ACCOUNTING AND TAX WORK NEVER SENT THE ORIGINAL RENEWAL IN. THE PERSON DOING MY WORK WENT IN FOR FOOT SURGERY AND THEY DISCOVERED A BRAIN TUMOR.

I WAS NOT AWARE THIS HAD NOT BEEN TAKEN CARE OF UNTIL I RECEIVED THE APPLICATION FOR REINSTATEMENT.

ANY CONSIDERATION IN THIS MATTER WOULD BE APPRECIATED.

SINCERELY:

Sheryl Anne Cammenga

SHERYL ANNE CAMMENGA
772-467-2674