

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

FILED
CLERK OF STATE
DIVISION OF CORPORATIONS
04 APR 20 PM 2:50

**CORPORATION
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # **P99000046798**

1. Corporation Name

Nalda Family CHIROPRAETIC Center Inc.

REINSTATEMENT 03-04

2. Principal Office Address

4041 13th St

Suite, Apt. #, etc.

3. Mailing Office Address

PO BOX 760116

Suite, Apt. #, etc.

City & State

St Cloud FL

City & State

St Cloud, FL

Zip

34769

Country

OSCEOLA

Zip

34770-0116

Country

OSCEOLA

100031700721

04/01/04--01048--014 **300.00

4. Date Incorporated or Qualified
To Do Business in Florida

5. FEI Number

Applied For

Not Applicable

6. CERTIFICATE OF STATUS DESIRED ☐

\$8.75 Additional Fee required
for a Certificate of Status

7. Name and Address of Current Registered Agent

Name

Anthony G. Nalda

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

1820 Sir Lancelot Circle

Suite, Apt. #, Etc.

City

St Cloud

State

FL

Zip Code

34772

8. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of section 607.0505 or 617.0503, F.S.

Signature of
Registered Agent

[Signature]

REGISTERED AGENT MUST SIGN

Date

04/12/04

9. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at least 3 directors)

Titles	Name of Officers and/or Directors	Street Address of Each Officer and/or Director	City / State / Zip
PT	Anthony G. Nalda	1820 Sir Lancelot Cir.	St Cloud, FL 34772
VPS	Martiezy Nalda	1820 Sir Lancelot Cir.	St Cloud, FL 34772

10. 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 AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

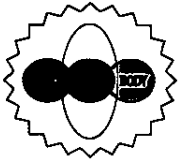
Date

03/17/04 407-951-1337

Daytime Phone #

CR2E081 (01/04)

NALDA FAMILY



CHIROPRACTIC

DR. ANTHONY NALDA
PRINCIPLED FAMILY CHIROPRACTOR
4041 13TH STREET

SAINT CLOUD, FLORIDA 34769
407.957.1337 FAX: 407.957.1848
WWW.NALDACHIROPRACTIC.COM

MARCH 17, 2004

TO WHOM IT MAY CONCERN,

WE DID NOT AT ANY POINT RECEIVE THE RENEWAL FORM FOR THE YEAR 2003 OR 2004. I AM NOT SURE IF IT IS DUE TO AN ADDRESS ISSUE. PLEASE REINSTATE US AS SOON AS POSSIBLE. A CHECK IS INCLUDED IN THE AMOUNT OF \$300 FOR 2003 AND FOR 2004. THANK YOU SO MUCH FOR YOUR UNDERSTANDING.

THE CURRENT MAILING ADDRESS IS :

NALDA FAMILY CHIROPRACTIC CENTER
PO Box 700116
ST. CLOUD, FL 34770-0116

Anthony Nalda - vice President