10f2

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM. H030000464542

CORPORATION REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
[redacted]
Secretary of State
DIVISION OF CORPORATIONS

FILED
03 FEB 07 AM 10:23
TALLAHASSEE, FLORIDA

DOCUMENT # P99000071154

REINSTATEMENT 01-03

1. Corporation Name
Center for Progressive Pain Management Inc

2. Principal Office Address	3. Mailing Office Address
500 SE 17 St	500 SE 17 St
Suite, Apt. #, etc. #230	Suite, Apt. #, etc. #230
City & State Ft. Laud., FL	City & State Ft. Laud., FL
Zip 33301 Country USA	Zip 33301 Country USA

4. Date Incorporated or Qualified To Do Business in Florida 7-30-99

5. FEI Number 650945950 ☐ 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: Patricia Halprin
Street Address (P.O. Box Number is Not Acceptable): 130 NE 16 Terr
Suite, Apt. #, Etc.:
City: Ft. Laud
State: FL Zip Code: 33301

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: X
REGISTERED AGENT MUST SIGN
Date: 02-07-03

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
PV ST	David Blyweiss	1154 NW 108 Terr	Plantation, FL 33322
D	Patricia Halprin	130 NE 16 Terr	Ft. Laud. FL 33301
m	Carlie Hupmon	5402 Godfrey Rd	Palm Bch, FL 33067

CR2E083 (1/01)

10. I certify that I am an officer or director of 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 Patricia Halprin
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR
02-07-03 954-658-1035
Date Daytime Phone #

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Florida Department of State
Division of Corporations
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(((H03000046454 2)))

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To:
Division of Corporations
Fax Number : (850)205-0384

From:
Account Name : CORPORATION SERVICE COMPANY
Account Number : I20000000195
Phone : (850)521-1000
Fax Number : (850)521-1030

CORPORATION REINSTATEMENT

CENTER FOR PROGRESSIVE PAIN MANAGEMENT, INC.

Certificate of Status	1
Certified Copy	0
Page Count	02
Estimated Charge	$1,058.75