PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

2001 APPLICATION FOR REINSTATEMENT UBR

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

1 of 2

FILED
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SECRETARY OF STATE
TALLAHASSEE FLORIDA

DOCUMENT # S16737

1. Corporation Name

CENTER FOR RESEARCH AND TREATMENT OF TMJ, HEADACHES AND FACIAL PAIN, A PROFESSIONAL ASSOCIATION

Principal Place of Business	Mailing Address
7410 MERRILL RD #2 JACKSONVILLE FL 32277-3711	7410 MERRILL RD #2 JACKSONVILLE FL 32277-3711

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: 10/15/1990

5. FEI Number: 59-3041508 ☐ 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	DRAPER, STEPHEN W.	2303 SHIPWRECK DRIVE	JACKSONVILLE FL
VP	DRAPER, LANDRA C.	2303 SHIPWRECK DRIVE	JACKSONVILLE FL

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-12/10/01--01098--013
****150.00 ****150.00

8. Name and Address of Current Registered Agent	9. Name and Address of New Registered Agent
DRAPER, STEPHEN W. 2303 SHIPWRECK DRIVE JACKSONVILLE FL 32224	Name Street Address (P.O. Box Number is Not Acceptable) Suite, Apt. #, Etc. City / State: FL / Zip Code

CR2E040 (8/01)

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 _____ Date 10/31/01
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.

Stephen W. Draper Landra C. Draper

SIGNATURE: _____ Landra C. Draper 10/31/01 (904) 745-5115
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

2062

CENTER FOR RESEARCH & TREATMENT OF TMJ, HEADACHES & FACIAL PAIN, P.A.

STEPHEN W. DRAPER, D.M.D.

7410 MERRILL ROAD
JACKSONVILLE, FLORIDA 32211

TELEPHONE (904) 745-5115

DIPLOMATE: AMERICAN ACADEMY OF PAIN MANAGEMENT

FELLOW, INTERNATIONAL COLLEGE OF CRANIO-MANDIBULAR ORTHOPEDICS

AMERICAN ACADEMY OF GNATHOLOGIC ORTHOPEDICS

AMERICAN ACADEMY & BOARD OF HEAD, NECK, FACIAL PAIN & TMJ ORTHOPEDICS, MEMBER

THE AMERICAN ASSOCIATION OF FUNCTIONAL ORTHODONTICS

FELLOW, THE AMERICAN ORTHODONTIC SOCIETY

October 31, 2001

Florida Department of State
Division of Corporations
Post Office Box 6327
Tallahassee, Florida 32314

Dear Sirs:

This is in response to the "Notice of Administrative Dissolution" that I received on 10/24/01. Due to the fact of my being out of the office, due to an illness that ultimately resulted in surgery, the filing of the annual report was overlooked. My office manager, who is also my wife, was out of the office during this time as well. Please accept my check in the amount of $150.00 for the reinstatement fee along with the application. If you have any questions please feel free to contact my office.

Sincerely,

Stephen W. Draper, DMD

SWD/slj