

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION
FOR
REINSTATEMENT



FLORIDA DEPARTMENT OF STATE

Katherine Harris

Secretary of State

DIVISION OF CORPORATIONS

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

7410 MERRILL RD

#2

#2

JACKSONVILLE FL 32277-3711

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

4. Date Incorporated or Qualified To Do Business in Florida

10/15/1990

Suite, Apt. #, etc.

Suite, Apt. #, etc.

5. FEI Number

59-3041508

Applied For

City & State

City & State

Not Applicable

Zip

Country

Zip

Country

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)	Name of Officers and/or Directors	Street Address of Each Officer and/or Director	City / State / Zip
P	DRAPER, STEPHEN W.	2303 SHIPWRECK DRIVE	JACKSONVILLE FL
VP	DRAPER, LANDRA C.	2303 SHIPWRECK DRIVE	JACKSONVILLE FL

500004717115-7
-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

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

REGISTERED AGENT MUST SIGN

Date

10/31/01

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:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

Stephen W. Draper

Landra C. Draper

10/31/01

(904) 745-5115

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

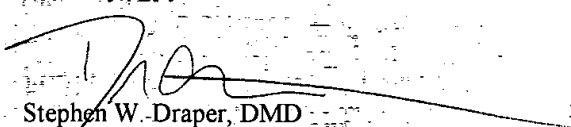
October 31, 2001

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