PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION FOR REINSTATEMENT

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

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FILED
SECRETARY OF STATE
DIVISION OF CORPORATIONS
01 OCT 15 PM 7:15

DOCUMENT # V28240

1. Corporation Name

CHIROMED CHIROPRACTIC CENTER, INC.

Principal Place of Business	Mailing Address
P.O. BOX 152517 TAMPA FL 33684	P.O. BOX 152517 TAMPA FL 33684

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. SAME	Suite, Apt. #, etc. SAME AS
City & State AS ABOVE	City & State Above
Zip / Country	Zip / Country

4. Date Incorporated or Qualified To Do Business in Florida: 04/13/1992

5. FEI Number: 59-3127384 ☐ 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
PD	BROWN, HARRY W.	750 MORROW INDUSTRIAL BLVD.	JONESBORO GA 30236
S	BROWN, NANCY	750 MORROW INDUSTRIAL BLVD.	JONESBORO GA 30236
V	MANGELSDOF, KENNETH J.	~~8 CHESTY PLACE~~ 226 GREEN ISLAND Rd	SAVANNAH GA 31411

600004655416--2
-10/26/01--01071--010
****150.00 ****150.00

8. Name and Address of Current Registered Agent	9. Name and Address of New Registered Agent
MANGELSDORF, JERRY 18120 LEAFWOOD CIRCLE TAMPA FL 33549	Name Street Address (P.O. Box Number is Not Acceptable) SAME 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.

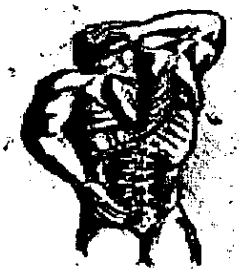
AD

Signature of Registered Agent X Jerry Mangelsdorf SIGNATURE REQUIRED
REGISTERED AGENT MUST SIGN

Date 10-12-01

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: X Harry W. Brown D.C. 10-12-01 (813) 931-7246
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #



CHIRO MED℠

CHIROPRACTIC CENTERS

PO BOX 152517 TAMPA, FLORIDA 33684
Phone (813) 931-7246 **Fax (813) 931-7102**

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October 12, 2001

Division of Corporations
PO Box 6327
Tallahassee, FL 32314

To Whom It May Concern:

As per our conversation on 10/12/2001, this is the first notification we received as far as maintaining active status by providing and annual report. In the past we have always handled this manner immediately through our accountants. Please take this under consideration and we hope that you will be able to waive the penalty fee. Enclosed is a check for 150.00. We appreciate your understanding.

If any additional information is required please notify by phone at (813) 931-7246 or by mail at the above letterhead address.

Respectfully Submitted,

Jerry Mangelsdorf
ChiroMed Office Manager
Current Registered Agent