

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

APPLICATION  
FOR  
REINSTATEMENT



FLORIDA DEPARTMENT OF STATE  
**Glenda E. Hood**  
Secretary of State  
DIVISION OF CORPORATIONS

FILED

03 OCT 15 AM 9:44

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

DOCUMENT # **V51185**

1. Corporation Name

**MARTINEZ CHIROPRACTIC CENTER, INC.**

Principal Place of Business

15118 S.W. SUNSET DR.  
MIAMI FL 33193

Mailing Address

15118 S.W. SUNSET DR.  
MIAMI FL 33193

If above addresses are incorrect in any way, line through incorrect information and enter correction below.

2. New Principal Office Address, If Applicable

~~12821 SW 88 ST~~

Suite, Apt. #, etc.

3. New Mailing Office Address, If Applicable

~~12821 SW 88 ST~~

Suite, Apt. #, etc.

4. Date Incorporated or Qualified  
To Do Business in Florida

07/16/1992

5. FEI Number

65-0348913

Applied For

Not Applicable

City & State

Miami FL

City & State

Miami FL

Zip

33186

Country

USA

Zip

33186

Country

USA

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
D	MARTINEZ, DAMIAN	15532 S.W. 148TH TR.	MIAMI FL 33196

600023819726  
10/15/03--01059--004 \*\*150.00

8. Name and Address of Current Registered Agent

MARTINEZ, DAMIAN  
11465 SW 110 LANE  
MIAMI FL 33173

9. Name and Address of New Registered Agent

Name  
DAMIAN MARTINEZ  
Street Address (P.O. Box Number is Not Acceptable)  
1710 Bay Drive  
Suite, Apt. #, Etc.

City  
Miami Beach

State  
FL

Zip Code  
33141

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. or 617.0505, F.S.

Signature of  
Registered Agent

*[Signature]*

Date

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.

SIGNATURE:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

10/10/03

CR2E04G (7/03)

# CHIROPRACTIC CENTERS



Dr. Joseph M. Buckley  
Dr. Damian Martinez  
Dr. Raul Rodriguez

To whom it may concern,

This letter is in response to the administrative dissolution or revocation of document # V51185. We never received the annual report due to the fact that we moved to a new location and I no longer reside at the address you have on file. Please update your record. Enclosed you will find payment in the amount of one hundred & fifty dollars. If you should have any question please do not hesitate in contacting our office.

Sincerely

  
Damian Martinez, D.C.

## **PINES WEST CHIROPRACTIC**

17035 Pines Blvd.

Pembroke Pines, FL 33027

Tel: 954-432-3343

Fax: 954-450-2565

## **MARTINEZ CHIROPRACTIC CENTER**

12821 SW 88 Street

Miami, FL 33186

Tel: 305-388-7577

Fax: 305-388-7851