2006 LIMITED LIABILITY COMPANY ANNUAL REPORT

FILED
Apr 11, 2006 08:00 AM
Secretary of State

DOCUMENT # L00000004529

1. Entity Name
NEUROSURGICAL CONSULTANTS OF SOUTH FLORIDA, L.L.C.

Principal Place of Business	Mailing Address
5130 LINTON BLVD STE E-3 DELRAY BEACH, FL 33484	201 S. BISCAYNE BLVD. SUITE 2000 MIAMI, FL 33131

02172006 Chg-LLC CR2E083 (11/05)

2. Principal Place of Business		3. Mailing Address	
Suite, Apt. #, etc.		Suite, Apt. #, etc.	
City & State		City & State	
Zip	Country	Zip	Country

4. FEI Number 65-1002459 ☐ Applied For ☐ Not Applicable

5. Certificate of Status Desired ☐ $5.00 Additional Fee Required

6. Name and Address of Current Registered Agent

SPRATT, WILLIAM J JR
C/O KIRKPATRICK & LOCKHART LLP
201 SOUTH BISCAYNE BOULEVARD, 20TH FLOOR
MIAMI, FL 33131

7. Name and Address of New Registered Agent

Name

Street Address (P.O. Box Number is Not Acceptable)

City FL Zip Code

8. The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. I am familiar with, and accept the obligations of registered agent.

SIGNATURE ______ Signature, typed or printed name of registered agent and title if applicable (NOTE: Registered Agent signature required when reinstating) DATE

Filing Fee is $50.00
Due by May 1, 2006

Make check payable to Florida Department of State

9. MANAGING MEMBERS/MANAGERS			10. ADDITIONS/CHANGES	
TITLE	MGRM	☐ Delete	TITLE	☐ Change ☐ Addition
NAME	SACHS, DAVID P MD PA		NAME	U00000502420
STREET ADDRESS	5130 LINTON BLVD STE E-3		STREET ADDRESS	04/25/06-80103-010 50.00
CITY-ST-ZIP	DELRAY BEACH, FL 33484		CITY-ST-ZIP	
TITLE	MGRM	☐ Delete	TITLE	☐ Change ☐ Addition
NAME	FLORIDA NEUROSCIENCE INSTITUTE LLC		NAME	
STREET ADDRESS	5130 LINTON BLVD		STREET ADDRESS	
CITY-ST-ZIP	DELRAY BEACH, FL 33484		CITY-ST-ZIP	
TITLE		☐ Delete	TITLE	☐ Change ☐ Addition
NAME			NAME	
STREET ADDRESS			STREET ADDRESS	
CITY-ST-ZIP			CITY-ST-ZIP	
TITLE		☐ Delete	TITLE	☐ Change ☐ Addition
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STREET ADDRESS			STREET ADDRESS	
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NAME			NAME	
STREET ADDRESS			STREET ADDRESS	
CITY-ST-ZIP			CITY-ST-ZIP	
TITLE		☐ Delete	TITLE	☐ Change ☐ Addition
NAME			NAME	
STREET ADDRESS			STREET ADDRESS	
CITY-ST-ZIP			CITY-ST-ZIP	

11. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Chapter 119, Florida Statutes. I further certify that the information indicated on this report is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am a managing member or manager of the limited liability company or the receiver or trustee empowered to execute this report as required by Chapter 608, Florida Statutes.

SIGNATURE: David P Sachs, M.D. 3/2/06 561-499-5633

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE — Date — Daytime Phone #