

**2008 LIMITED LIABILITY COMPANY  
ANNUAL REPORT (AR) - DUE BY MAY 1, 2008**

**FILED**  
**Apr 15, 2008 8:00 am**  
**Secretary of State**

04-15-2008 90114 002 \*\*\*138.75

**DOCUMENT # L00000004529**

1. Entity Name

**NEUROSURGICAL CONSULTANTS OF SOUTH FLORIDA,  
L.L.C.**



Principal Place of Business

**5130 LINTON BLVD  
STE E-3  
DELRAY BEACH FL 33484**

Mailing Address

**201 S. BISCAYNE BLVD.  
SUITE 2000  
MIAMI FL 33131**

2. Principal Place of Business - No P.O. Box #

**670 Glades Road**

Suite, Apt. #, etc.

**Suite 100**

City & State

**Boca Raton, FL**

Zip

**33431**

Country

3. Mailing Address

**670 Glades Road**

Suite, Apt. #, etc.

**Suite 100**

City & State

**Boca Raton, FL**

Zip

**33431**

Country

1st MOORE

CR2E083 (10/07)

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

**LAWLER, PATRICK W.  
2925 W CYPRESS CREEK RD #102  
FORT LAUDERDALE FL 33309**

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 fee if applicable

(NOTE: Registered Agent signature required when registering)

DATE

**FILE NOW!!! FEE IS \$138.75  
After May 1, 2008, Fee Will Be \$538.75  
Make Check Payable to Florida Department of State**

9. MANAGING MEMBERS/MANAGERS

TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM SACHS, DAVID P MD PA 5130 LINTON BLVD STE E-3 DELRAY BEACH FL 33484	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM FLORIDA NEUROSCIENCE INSTITUTE LLC 5130 LINTON BLVD STE E-3 DELRAY BEACH FL 33484	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP	MGRM PALM BEACH NEURISCIENCES, LLC 5130 LINTON BLVD STE E-3 DELRAY BEACH FL 33484	<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Delete

10. ADDITIONS/CHANGES

TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition
TITLE NAME STREET ADDRESS CITY-ST-ZIP		<input type="checkbox"/> Change <input type="checkbox"/> Addition

11. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Section 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:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE

*David P Sachs, M.D.*

03/14/08

Digitized Private #