
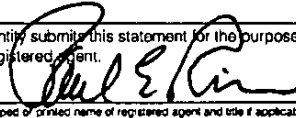
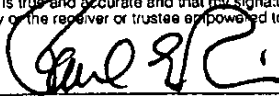


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L05000100097

2006 LIMITED LIABILITY COMPANY ANNUAL REPORT

| | | | |
|--|---------------------------------|---|--|
| DOCUMENT # L05000100097 | |  | |
| 1. Entity Name INSTITUTE FOR IMMERSIVE VISUALIZATION, LLC | | | |
| Principal Place of Business 800 MEADOWS ROAD BOCA RATON, FL 33486 | | Mailing Address 800 MEADOWS ROAD BOCA RATON, FL 33486 | |
| 2. Principal Place of Business | | 3. Mailing Address | |
| Suite, Apt. #, etc. | | Suite, Apt. #, etc. | |
| City & State | | City & State | |
| Zip | Country | Zip | Country |
| 6. Name and Address of Current Registered Agent RISNER, PAUL E ESQ 800 MEADOWS ROAD BOCA RATON, FL 33486 | | 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:  (NOTE: Registered Agent signature required when reappointing) 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 NAME STREET ADDRESS CITY - ST - ZIP Eugene M. and Christine E. Lynn Clinical Research Institute, LLC 800 meadows Road Boca Raton FL 33486 | <input type="checkbox"/> Delete | TITLE NAME STREET ADDRESS CITY - ST - ZIP EUGENE M. and Christine E. Lynn Clinical Research Institute, LLC 800 Meadows Rd. Boca Raton FL 33486 | <input type="checkbox"/> Change <input checked="" type="checkbox"/> Addition |
| TITLE NAME STREET ADDRESS CITY - ST - ZIP | <input type="checkbox"/> Delete | 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"/> Delete | TITLE NAME STREET ADDRESS CITY - ST - ZIP | <input type="checkbox"/> Change <input type="checkbox"/> Addition |
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| TITLE NAME STREET ADDRESS CITY - ST - ZIP | <input type="checkbox"/> Delete | 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 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:  | | 4/28/06 (SW) 955-4203 | |
| SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE | | Date Daytime Phone # | |

ATTACHMENT

28043333

L05000100097

**PLEASE RETURN
CERTIFICATE OF STATUS TO:**

**DEBBIE L. GALLUZZO
ADMINISTRATION DEPT.
BOCA RATON COMMUNITY
HOSPITAL
800 MEADOWS ROAD
BOCA RATON, FLORIDA 33498**

THANK YOU