
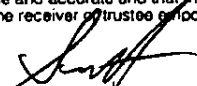


2007 LIMITED LIABILITY COMPANY ANNUAL REPORT

FILED
May 21, 2007 8:00 am
Secretary of State

04-27-2007 90038 020 ****50.00

DOCUMENT # L06000101371 1. Entity Name PERINATAL DIAGNOSTIC INSTITUTE, PL					
Principal Place of Business 560 VILLAGE BLVD., STE. 335 WEST PALM BEACH, FL 33409			Mailing Address 560 VILLAGE BLVD., STE. 335 WEST PALM BEACH, FL 33409		
2. Principal Place of Business - No P.O. Box #		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 MCKENNA, CHRISTINE 560 VILLAGE BLVD., STE. 335 WEST PALM BEACH, FL 33409				7. Name and Address of New Registered Agent Name Street Address (P.O. Box Number is Not Acceptable) City <div style="display: flex; justify-content: space-between;"> FL Zip Code </div>	
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 renewing) DATE _____					
Filing Fee is \$50.00 Due by May 1, 2007		Make check payable to Florida Department of State			
9. MANAGING MEMBERS/MANAGERS			10. ADDITIONS/CHANGES		
TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Delete		TITLE NAME STREET ADDRESS CITY-ST-ZIP	<input type="checkbox"/> Change <input checked="" 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: 			Seth J Herbst MD		
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING MANAGING MEMBER, MANAGER, OR AUTHORIZED REPRESENTATIVE			Date 4/23/07 Daytime Phone # 561-798-8975		

