

# 2008 LIMITED LIABILITY COMPANY ANNUAL REPORT

DOCUMENT# L07000012195

**FILED**  
**May 20, 2008**  
**Secretary of State**

**Entity Name:** BROAD PAIN CARE CONSULTANTS, LLC

**Current Principal Place of Business:**

501 GLADES ROAD  
BOCA RATON, FL 33432

**New Principal Place of Business:**

1601 CLINT MOORE ROAD  
SUITE 160  
BOCA RATON, FL 33487

**Current Mailing Address:**

501 GLADES ROAD  
BOCA RATON, FL 33432

**New Mailing Address:**

**FEI Number:** 20-8392944      **FEI Number Applied For ( )**      **FEI Number Not Applicable ( )**      **Certificate of Status Desired (X)**  
In accordance with s. 607.193(2)(b), F.S., the limited liability company did not receive the prior notice.

**Name and Address of Current Registered Agent:**

RODGER, HOCHMAN L ESQ.  
1900 GLADES ROAD  
SUITE 350  
BOCA RATON, FL 33431 US

**Name and Address of New Registered Agent:**

HARVEY, PLOSKER  
501 GLADES ROAD  
BOCA RATON, FL 33432 US

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.

SIGNATURE: HARVEY PLOSKER

05/20/2008

Electronic Signature of Registered Agent

Date

**MANAGING MEMBERS/MANAGERS:**

Title: MGRM ( ) Delete  
Name: BROAD ANESTHESIA ASS, OCIATES, A GEN PARTNER  
Address: 501 GLADES ROAD  
City-St-Zip: BOCA RATON, FL 33432

**ADDITIONS/CHANGES:**

Title: ( ) Change ( ) Addition  
Name:  
Address:  
City-St-Zip:

I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Chapter 119, Florida Statutes. I further certify that the information indicated on this report is true and accurate and that my electronic 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: HARVEY PLOSKER

MGR

05/20/2008

Electronic Signature of Signing Managing Member, Manager, or Authorized Representative / Date