

# 2008 LIMITED LIABILITY COMPANY ANNUAL REPORT

**FILED**  
**Mar 10, 2008 8:00 am**  
**Secretary of State**

03-10-2008 90339 040 \*\*\*138.75

**DOCUMENT # L07000056304**

1. Entity Name  
ADVANCED UROLOGICAL TECHNOLOGIES, L.L.C.



Principal Place of Business  
1461 SHADY MEADOW LANE  
DELAND, FL 32724

Mailing Address  
1461 SHADY MEADOW LANE  
DELAND, FL 32724

**60013661**



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

3. Mailing Address

*PO Box 2932*

03072008 Chg-LLC CR2E083 (12/06)

Suite, Apt. #, etc.

Suite, Apt. #, etc.

City & State

City & State

*SPARKANE, WA*

4. FEI Number

*36-4610204*

Applied For

Not Applicable

Zip

Country

Zip

Country

*99220-2932*

5. Certificate of Status Desired ☐

**\$5.00** Additional  
Fee Required

6. Name and Address of Current Registered Agent

7. Name and Address of New Registered Agent

PEARSON, JOHN M.D.  
6100 MINTON ROAD  
PALM BAY, FL 32907

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

**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	<input type="checkbox"/> Delete

10. ADDITIONS/CHANGES

TITLE	NAME	STREET ADDRESS	CITY-ST-ZIP	<input type="checkbox"/> Change <input type="checkbox"/> Addition
<i>MGRM</i>	<i>JOHN PEARSON, MD</i>	<i>1461 SHADY MEADOW LANE</i>	<i>DELAND, FL 32724</i>	
<i>MGRM</i>	<i>PROSTATE TREATMENT CENTERS, LLC</i>	<i>200 N. MULLAN RD, SUITE 201</i>	<i>SPARKANE VALLEY, WA 99206</i>	

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:

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

Date

Daytime Phone #

*PROSTATE TREATMENT CENTERS, LLC*  
*By [Signature]*

*3.7.08 (SDA) 838-2866*