

A. Ralph Mollis, Secretary of State Corporations Division 148 W. River Street Providence, RI 02904-2615

401.222.3040

2011 PROFIT CORPORATION ANNUAL REPORT FOR THE YEAR

| 7.25 Reservoir Avenue, Suite 203 To operate a medical office. State of Incorporation River Production River Production | 5925 | | 2. Name of Corporation Comprehensive OB/GYN Care, Inc. | | | | |
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| Proceedings Process | | | | | ^{Ζψ} 0291 0 | | |
| To operate a medical office. NAMES AND ADDRESSES OF THE OFFICERS: ("X" BOX FOR ATTACHMENT) FILL IN SPACES BEFORE USING ATTACHMENT Fill IN SPACES BEFORE USI | | | | · • | | | |
| Vice President Name | | | ted in Rhode Island | | | | |
| 25 Reservoir Avenue, Suite 203 Cranston, RI 02910 City State Zig Condition State RI 02910 Treasurer Name Michael Coppa, MD Treasurer Name State Address 25 Reservoir Avenue, Suite 203 Figure 1 | ent Name | S OF THE OFFI | CERS: ("X" BOX FOR ATTA | | SPACES BEFORE USING | ATTACHMENTS | |
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| A. Michael Coppa, MD Treet Address 725 Reservoir Avenue, Suite 203 Transton State RI O2910 A. NAMES AND ADDRESSES OF THE DIRECTORS: ("X" BOX FOR ATTACHMENT) FILL IN SPACES BEFORE USING ATTACHMENT The state Zip City State Zip The state Zip City State Zip The state Address Street Address The state Zip City State Zip The state Address Street Address The state Zip City State Zip The state Address Street Address The state Address Street | nston, | | | City | State | Zip | |
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| - 1,00 | State. Changes require an additional filing. See Section 9 of | | | Number of Shares | Class/Series | Par Value | |
| | | | | 100 | Common | .01 | |
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| This report must be executed on behalf of the corporation by an authorized representative. If the corporation is in the hands of a remaining report must be executed on behalf of the corporation by the receiver or trustee. | | | | | corporation is in the hand | s of a receiver o | |

| | FILED |
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| File Date | JAN 3 1 2011` |
| Check No | v ~2801 |
| Ву: | FOR SECRETARY OF STATE USE ONLY |

| Under penalty of perjury, I declars and affirm | |
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| including any accompanying schedules and s | statements, and that all statements |
| contained herein are true and correct. | ////////////////////////////////////// |
| A. Tynair la | Mes 1/20/ |
| Signature | Ddte |
| A. Michael Coppa, MD | / |
| Print or Type Name | |
| President | |
| Title | |
| | Form 630 Rev. 08/08 |