



State of Rhode Island
and Providence Plantations
Office of the Secretary of State

A. Ralph Mollis, Secretary of State
Corporations Division
148 W. River Street
Providence, RI 02904-2615
401.222.3040

LIMITED LIABILITY COMPANY ANNUAL REPORT FOR THE YEAR 2010

Filing Period: September 1 - November 1 • **Filing Fee:** \$50.00* • **THIS REPORT MUST BE TYPED OR PRINTED LEGIBLY IN BLACK INK.**

* In accordance with R.I.G.L. 7-16-66 (d), each limited liability company failing or refusing to file its annual report within thirty (30) days after the time prescribed by law (R.I.G.L. 7-16-66 (b)(v)) is subject to a penalty fee of \$25.00.

1. ID No. 159833		2. Exact name of the limited liability company Thomas David Puleo MD LLC			
3. State of Formation Rhode Island		4. Brief description of the character of the business which is actually conducted in Rhode Island Medical Office			
5. Principal office address 1220 Pontiac Ave Suite 302			City Cranston	State Rhode Island	Zip 02920
6. MAILING ADDRESS OF LIMITED LIABILITY COMPANY AND NAME OR TITLE OF CONTACT PERSON:					
Contact Name Dr Thomas Puleo MD			Contact Title Member		
Street Address 233 Norwood Ave			City Cranston	State Rhode Island	Zip 02905
7. NAME AND ADDRESS OF EACH MANAGER OF THE LIMITED LIABILITY COMPANY, IF APPLICABLE - DO NOT LIST MEMBERS FILL IN SPACES BEFORE USING ATTACHMENTS ("X" BOX FOR ATTACHMENT) <input type="checkbox"/>					
Manager Name			Manager Name		
Street Address			Street Address		
City	State	Zip	City	State	Zip
Manager Name			Manager Name		
Street Address			Street Address		
City	State	Zip	City	State	Zip
8. RESIDENT AGENT IN RHODE ISLAND This information is currently of record in the Office of the Secretary of State. Changes require filing of Form 642 - R.I.G.L. 7-16-11					

FILED

MAR 17 2011

By 140273 DS

This report must be executed by an authorized person pursuant to R.I.G.L. 7-16-66 (b).

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SECRETARY OF STATE
CORPORATIONS DIV
2011 MAR 17 AM 11:35

20-5906467

Under penalty of perjury, I declare and affirm that I have examined this report, including any accompanying schedules and statements, and that all statements contained herein are true and correct.

File Date _____
Check No. _____
By: _____
FOR SECRETARY OF STATE USE ONLY

Signature of Authorized Person

Date

Dr. Thomas Puleo MD

Print or Type Name of Authorized Person

3/16/11