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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 2012

**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&c)) is subject to a penalty fee of $25.00.*

| 1. ID No. | 2. Exact name of the limited liability company |
|---|---|
| 592703 | Newport Family Foot Care, LLC |

| 3. State of Formation | 4. Brief description of the character of the business which is actually conducted in Rhode Island |
|---|---|
| RI | Podiatry office |

| 5. Principal office address | City | State | Zip |
|---|---|---|---|
| 392 Broadway | Newport | RI | 02840 |

**6. MAILING ADDRESS OF LIMITED LIABILITY COMPANY AND NAME OR TITLE OF CONTACT PERSON:**

| Contact Name | Contact Title |
|---|---|
| Jordan Sheff, DPM | Owner |

| Street Address | City | State | Zip |
|---|---|---|---|
| Same | | | |

**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) ☐

| Manager Name | Manager Name |
|---|---|
| NA | |
| 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

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

FILED

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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.

08/20/2012

*Signature of Authorized Person* *Date*

JORDAN SHEFF, DPM

*Print or Type Name of Authorized Person*

*File Date* _____

*Check No.* _____

*By:* _____

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Form 632 Rev. 08/08