



**STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS**  
**Office of the Secretary of State - Division of Business Services**  
 148 W. River Street, Providence, Rhode Island 02904-2615  
 Phone: (401) 222-3040 ~ Email: corporations@sos.ri.gov ~ Website: www.sos.ri.gov

## LIMITED LIABILITY COMPANY ANNUAL REPORT FOR THE YEAR **2012**

Filing Period: September 1 - November 1 • This report must be typed or printed legibly.

Filing Fee: \$50.00 • FAILURE TO FILE THIS REPORT BY DECEMBER 1 WILL RESULT IN A \$25.00 PENALTY FEE.

1. Entity ID No. <b>571422</b>		2. Exact name of the limited liability company <b>IDEAL WEIGHT LOSS LLC</b>			
3. State of Formation <b>RHODE ISLAND</b>		4. Brief description of the character of business conducted in Rhode Island <b>WEIGHT LOSS CLINIC</b>			
5. Principal office address <b>2 Wake Robin Road</b>			City <b>Lincoln</b>	State <b>RI</b>	Zip <b>02865</b>
<b>6. MAILING ADDRESS OF LIMITED LIABILITY COMPANY AND NAME OR TITLE OF CONTACT PERSON:</b>					
Contact Name <b>Joseph Raheb</b>			Contact Title <b>Attorney</b>		
Street Address <b>650 Washington Hwy.</b>			City <b>Lincoln</b>	State <b>RI</b>	Zip <b>02865</b>
<b>7. LIST ALL MANAGERS (NAMES AND ADDRESSES) OF THE LIMITED LIABILITY COMPANY, IF APPLICABLE - DO NOT LIST MEMBERS ("X" BOX FOR ATTACHMENT) <input type="checkbox"/></b>					
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
<b>8. RESIDENT AGENT IN RHODE ISLAND</b>					
This information is currently of record in the Office of the Secretary of State. Changes require filing Form 642.					

**FILED** 1252  
 OCT 31 2012  
 BY 02182571

2012 OCT 31 PM 12:52  
 DEPARTMENT OF STATE  
 CORPORATIONS DIV.

File Date \_\_\_\_\_

Check No \_\_\_\_\_

By: \_\_\_\_\_

**FOR SECRETARY OF STATE USE ONLY**

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.

Signature of Authorized Person

**FRANK M. D'ALESSANDRO, M.D.**

Print or Type Name of Authorized Person

Date: 10/2/12