



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

PROFIT CORPORATION ANNUAL REPORT FOR THE YEAR **2014**

Filing Period: January 1 - March 1 • This report must be typed or printed legibly.

Filing Fee: \$50.00 • FAILURE TO FILE THIS REPORT BY MARCH 31 WILL RESULT IN A \$25.00 PENALTY FEE.

1. Entity ID No. 115962		2. Exact name of the Corporation HABER-DIBONI CHIROPRACTIC, LTD.			
3. Principal office address 14 CEDAR SWAMP ROAD		City SMITHFIELD	State RI	Zip 02917	
4. Business Phone No. 401-233-0200		5. State of Incorporation RHODE ISLAND			
6. Brief description of the character of business conducted in Rhode Island TO OWN, MANAGE AND OTHERWISE CONDUCT THE PROFESSIONAL BUSINESS OF A CHIROPRACTIC MEDICAL PRACTICE.					
7. LIST ALL OFFICERS (NAMES AND ADDRESSES) ("X" BOX FOR ATTACHMENT) ☐					
President Name LORRI HABER-DIBONI		Vice-President Name SAME			
Street Address 1261 PHENIX AVENUE		Street Address			
City CRANSTON	State RI	Zip 02921	City	State	Zip
Secretary Name SAME		Treasurer Name SAME			
Street Address		Street Address			
City	State	Zip	City	State	Zip
8. LIST ALL DIRECTORS (NAMES AND ADDRESSES) ("X" BOX FOR ATTACHMENT) ☐					
Director Name NONE		Director Name			
Street Address		Street Address			
City	State	Zip	City	State	Zip
Director Name		Director Name			
Street Address		Street Address			
City	State	Zip	City	State	Zip
9. SHARES AUTHORIZED			10. SHARES ISSUED ("X" BOX FOR ATTACHMENT) ☐		
This information is currently of record in the Office of the Secretary of State. Changes require an additional filing. See Section 9 of Instruction sheet.			NUMBER OF SHARES	CLASS/SERIES	PAR VALUE
			200	COMMON	\$.01

This report must be executed on behalf of the corporation by an authorized representative. If the corporation is in the hands of a receiver or trustee, this report must be executed on behalf of the corporation by the receiver or trustee.

File Date _____

Check No. _____

By: _____

FOR SECRETARY OF STATE USE ONLY

FILED

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BY

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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.

X Dr. Lorri Haber-Diboni
Signature of Authorized Representative

02/17/2014

Date

DR. LORRI HABER-DIBONI

Print or Type Name of Authorized Representative