



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. 000117291		2. Exact name of the Corporation NORTH PROVIDENCE PRIMARY CARE ASSOCIATES, INC.			
3. Principal office address 1830 MINERAL SPRING AVENUE			City NORTH PROVIDENCE	State RI	Zip 02904
4. Business Phone No. 401-353-8135		5. State of Incorporation RI			
6. Brief description of the character of business conducted in Rhode Island PROFESSIONAL MEDICAL SERVICES BY PHYSICIANS SPECIALIZING IN INTERNAL MEDICINE AND DULY LICENSED TO PRACTICE MEDICINE IN THE STATE OF RHODE ISLAND.					
7. LIST ALL OFFICERS (NAMES AND ADDRESSES) ("X" BOX FOR ATTACHMENT) <input type="checkbox"/>					
President Name ANTHONY G. FARINA, JR., M.D.			Vice-President Name		
Street Address 1830 MINERAL SPRING AVENUE			Street Address		
City NORTH PROVIDENCE	State RI	Zip 02904	City	State	Zip
Secretary Name			Treasurer Name		
Street Address			Street Address		
City	State	Zip	City	State	Zip
8. LIST ALL DIRECTORS (NAMES AND ADDRESSES) ("X" BOX FOR ATTACHMENT) <input type="checkbox"/>					
Director Name BRENDA DELSIGNORE			Director Name		
Street Address 1830 MINERAL SPRING AVENUE			Street Address		
City NORTH PROVIDENCE	State RI	Zip 02904	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) <input type="checkbox"/>		
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
			8,000	CWP	1.00

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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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 Representative

Date

ANTHONY G. FARINA, JR., M.D.

Print or Type Name of Authorized Representative