



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 2015

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)(7c)) is subject to a penalty fee of \$25.00.

1. ID No. 998103		2. Exact name of the limited liability company COASTAL DENTAL ASSOCIATES, LLC			
3. State of Formation RHODE ISLAND		4. Brief description of the character of the business which is actually conducted in Rhode Island DENTAL PRACTICE			
5. Principal office address 171 Broadway		City Providence	State RI	Zip 02903	
6. MAILING ADDRESS OF LIMITED LIABILITY COMPANY AND NAME OR TITLE OF CONTACT PERSON:					
Contact Name Stacie Brito			Contact Title Administrator		
Street Address 282 286 Church Pond Drive		City Tiverton	State RI	Zip 02878	
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

NOV 23 2015

BY Ch 261782

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.

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.

Jennifer Kuchar, MD 11-10-15
Signature of Authorized Person Date

DR. JENNIFER KUCHAR
Print or Type Name of Authorized Person

File Date _____
Check No. 1290
By: _____
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