



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
Office of the Secretary of State
Matthew A. Brown, Secretary of State

Corporations Division
100 North Main Street
Providence, RI 02903-1335
401.222.3040

LIMITED LIABILITY COMPANY ANNUAL REPORT FOR THE YEAR 2005

Filing Period: September 1 - November 1 • Filing Fee: \$50.00

(FORM MUST BE TYPED OR PRINTED IN BLACK)

1. ID No. 142702		2. Exact name of the limited liability company Provant Health Solutions, LLC	
3. State of Formation RHODE ISLAND		4. Brief description of the character of the business which is actually conducted in Rhode Island WELLNESS CONSULTING	
5. Principal office address PO BOX 901		City EAST GREENWICH	State RI
		Zip 02818	
6. MAILING ADDRESS OF LIMITED LIABILITY COMPANY AND NAME OR TITLE OF CONTACT PERSON:			
Contact Name HEATHER ANN PROVINO		Contact Title	
Street Address 940 QUAKER LANE # 223		City EAST GREENWICH	State RI
		Zip 02818	
7. NAME AND ADDRESS OF EACH MANAGER OF THE LIMITED LIABILITY COMPANY, IF APPLICABLE FILL IN SPACES BEFORE USING ATTACHMENTS ("X" BOX FOR ATTACHMENT) ☐ ANY MODIFICATIONS TO MANAGERS REQUIRES FILING OF AMENDMENT, R.I.G.L. 7-16-12 (a) (2) / 7-16-52			
Manager Name		Manager Name	
Street Address		Street Address	
City	State	City	State
Zip		Zip	
Manager Name		Manager Name	
Street Address		Street Address	
City	State	City	State
Zip		Zip	
8. RESIDENT AGENT IN RHODE ISLAND - DO NOT ALTER - Changes require filing of Form 642 - R.I.G.L. 7-16-11			
Agent Name HEATHER ANN PROVINO		Address	
Address 940 QUAKER LANE, #223		City EAST GREENWICH	Zip 02818-

This report must be signed in ink by an authorized person pursuant to R.I.G.L. 7-16-66.



File Date	12/1/05	*142702*
Check No.	168	
By:	[Signature]	
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] **11-6-2005**
Signature of Authorized Person Date
HEATHER ANN PROVINO
Print or Type Name of Authorized Person