




State of Rhode Island and Providence Plantations
Department of State - Business Services Division

Annual Report for the year: **2017**

Corporation

- Filing period: January 1 - March 1
→ Filing Fee: \$50.00
→ Penalty: Additional \$25.00 fee if form is not filed by April 1.

1. Entity ID Number 486865		2. Exact name of the Corporation Internal Medicine Partners, Inc.			
3. Principal Office Address 1635 Mineral Spring Avenue		City North Providence		State RI	Zip 02904
4. NAICS Code 62 - Health Care and Social Ass		6. Brief description of the character of business conducted in Rhode Island Medical services.			
5. State of Incorporation Rhode Island					
7. List ALL officers (names and addresses) Check the box to indicate an attachment <input type="checkbox"/>					
President Name Puneet Sud, M.D.			Vice-President Name		
Street Address 1635 Mineral Spring Avenue			Street Address		
City North Providence	State RI	Zip 02904	City	State	Zip
Secretary Name Puneet Sud, M.D.			Treasurer Name Puneet Sud, M.D.		
Street Address 1635 Mineral Spring Avenue			Street Address 1635 Mineral Spring Avenue		
City North Providence	State RI	Zip 02904	City North Providence	State RI	Zip 02904
8. List ALL directors (names and addresses) Check the box to indicate an attachment <input type="checkbox"/>					
Director Name Puneet Sud, M.D.			Director Name		
Street Address 1635 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 Check the box to indicate an attachment <input type="checkbox"/>					
This information is currently of record in the Department of State. Changes require an additional filing.		10. Shares Issued Check the box to indicate an attachment <input type="checkbox"/>			
		NUMBER OF SHARES		CLASS/SERIES	PAR VALUE
		1,000	Common	\$0.01	
11. 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. 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.					
Name of Authorized Representative Puneet Sud, M.D.				Date 2/25/17	
Signature of Authorized Representative 					

MAIL TO:
Division of Business Services
148 W. River Street, Providence, Rhode Island 02904-2615
Phone: (401) 222-3040
Website: www.sos.ri.gov

FILED

MAR 03 2017

BY 3180 QS

FORM 630 - Revised: 10/2016