



State of Rhode Island and Providence Plantations

Department of State - Business Services Division**Statement of Change of Agent**

DOMESTIC or FOREIGN Limited Liability Company

→ Filing Fee: \$20.00

Pursuant to the provisions of RIGL 7-16-11 the undersigned limited liability company submits the following statement for the purpose of changing its resident agent in the State of Rhode Island:

1. Entity ID Number 787852		2. Exact Name of the Limited Liability Company Massage Health + Healing Energies, LLC	
3. The address of the resident office as PRESENTLY shown in the records on file with the RI Department of State:			
Street Address			
City/Town		State 1 RHODE ISLAND	Zip
4. The name of the resident agent as PRESENTLY shown in the records on file with the RI Department of State: 49 Weybosset Street, Second Floor Providence RI 02903 Tobias Lederberg, Esq.			
5. The address of the NEW resident office is:			
Street Address (NOT a P.O. Box) 12 Village Green North Apt A			
City/Town Riverside		State RHODE ISLAND	Zip 02915
6. The name of the NEW resident agent is: Deborah DeAngelis			
7. Date when this Statement of Change of Resident Agent will be effective: CHECK ONLY ONE BOX			
<input checked="" type="checkbox"/> Date received (Upon filing)			
<input type="checkbox"/> Later effective date (Date must be no more than 30 days from the day of filing) _____			
Under penalty of perjury, I declare and affirm that I have examined this Statement of Change of Resident Agent by the Limited Liability Company, and that all statements contained herein are true and correct.			
Name of Authorized Person of the Limited Liability Company Deborah DeAngelis			Date 6-28-17
Signature of Authorized Person of the Limited Liability Company Deborah DeAngelis SIGN DOCUMENT HERE			

RECEIVED
R.I. DEPT. OF STATE
BUS SVCS DIV
2017 JUN 28 PM 12:53

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**

JUN 28 2017

BY **601123**
A.A. 12:53 PM

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