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 CORPORATIONS DIV  
 2017 DEC 18 AM 10:30

**Article of Incorporation**  
 Professional Service Corporation

→ Filing Fee: \$230.00 minimum

The undersigned acting as incorporator(s) of a professional service corporation under RIGL 7-5.1 and 7-1.2, adopt(s) the following Articles of Incorporation for such corporation:

1. The name of the corporation is: <b>Critical Care Associates, P.C.</b>		
Is this a close corporation pursuant to RIGL 7-1.2-1701 of the General Laws, 1956, as amended? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
2. The profession to be practiced through the professional service corporation is: <b>Medicine</b>		
3. The total number of shares which the corporation has the authority to issue is: <i>(Unless otherwise stated, all authorized shares are deemed to have a nominal or par value of \$0.01 per share.)</i>		
<b>Total Authorized Shares (Number of Shares)</b>	<b>Class of Stock</b>	<b>Par Value Per Share</b>
1,500	common	\$0.01
If you desire, you may include a statement of all or any of the designations and the power, preferences, and rights, including voting rights, and the qualifications, limitations, or restrictions of them which are permitted by the provisions of RIGL 7-1.2. State any provisions here (optional). <span style="float: right;">Check the box to indicate an attachment. <input type="checkbox"/></span>		
4. The name and address of the initial registered agent/office in Rhode Island is:		
Agent Name <b>Khaled Sorour</b>		
Street Address (NOT a P.O. Box) <b>15 Millers Brook Dr.</b>		
City/Town <b>Cumberland</b>	State <b>RHODE ISLAND</b>	Zip Code <b>02864</b>
5. The corporation shall have perpetual existence until dissolved or terminated in accordance with RIGL 7-1.2.		

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**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**  
 DEC 18 2017  
 BY *[Signature]*  
 320014  
 11/18

6. Additional provisions, if any, not inconsistent with RIGL 7-1.2 which the incorporators elect to have set forth in these Articles of Incorporation:

Check the box to indicate an attachment.

7. The name and address of each incorporator is:

Name <b>Khaled Sorour</b>	Address <b>15 Millers Brook Dr.</b>	
City/Town <b>Cumberland</b>	State <b>RI</b>	Zip Code <b>02864</b>
Name	Address	
City/Town	State	Zip Code
Name	Address	
City/Town	State	Zip Code

8. Date when these Articles of Incorporation will be effective: CHECK ONLY ONE BOX

- Date received (Upon filing)  
 Later effective date (Date must be no more than 90 days from the day of filing) \_\_\_\_\_

*Under penalty of perjury, I/we declare and affirm that I/we have examined these Articles of Incorporation, including any accompanying attachments, and that all statements contained herein are true and correct.*

Signature of Incorporator  SIGN DOCUMENT HERE <b>KHALED Sorour</b>	Date <b>9/24/17</b>
Signature of Incorporator SIGN DOCUMENT HERE	Date
Signature of Incorporator SIGN DOCUMENT HERE	Date



MATRANE-01

ACOLUMBUS

# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

3/14/2017

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

**IMPORTANT:** If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

<b>PRODUCER</b> License # 1780862 HUB International New England 100 Central Street Suite 201 Holliston, MA 01746	<b>CONTACT NAME:</b> Donna Murphy <b>PHONE (A/C, No, Ext):</b> (774) 233-6201 <b>E-MAIL ADDRESS:</b> Donna.Murphy@hubinternational.com <b>FAX (A/C, No):</b> (866) 773-6540
<b>INSURER(S) AFFORDING COVERAGE</b>	
<b>INSURER A:</b> Connecticut Medical Insurance Company	
<b>INSURER B:</b>	
<b>INSURER C:</b>	
<b>INSURER D:</b>	
<b>INSURER E:</b>	
<b>INSURER F:</b>	

**INSURED**  
 Khaled Sorour, M.D.  
 Matrix Anesthesia, P.C.  
 c/o Health Management Associates  
 1342 Belmont St. Suite 205  
 Brockton, MA 02301

**COVERAGES**                      **CERTIFICATE NUMBER:**                      **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN. THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS

INSR LTR	TYPE OF INSURANCE	ADDL SUBR (USD, WVD)	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	<b>COMMERCIAL GENERAL LIABILITY</b> <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR  <input type="checkbox"/> GENL AGGREGATE LIMIT APPLIES PER POLICY <input type="checkbox"/> PRO <input type="checkbox"/> LOC <input type="checkbox"/> OTHER					EACH OCCURRENCE \$ _____ DAMAGE TO RENTED PREMISES (Ea. occurrence) \$ _____ MED EXP (Any one person) \$ _____ PERSONAL & ADV INJURY \$ _____ GENERAL AGGREGATE \$ _____ PRODUCTS - COMP/OP AGG \$ _____
	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON OWNED AUTOS ONLY					COMBINED SINGLE LIMIT (Ea. accident) \$ _____ BODILY INJURY (Per person) \$ _____ BODILY INJURY (Per accident) \$ _____ PROPERTY DAMAGE (Per accident) \$ _____
	<b>UMBRELLA LIAB</b> <input type="checkbox"/> OCCUR <b>EXCESS LIAB</b> <input type="checkbox"/> CLAIMS-MADE  <input type="checkbox"/> DED <input type="checkbox"/> RETENTION \$					EACH OCCURRENCE \$ _____ AGGREGATE \$ _____
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> <input type="checkbox"/> ANY PROPRIETOR/PARTNER/EXECUTIVE (+/- CER MEMBER EXC. UOED?) (Mandatory in NH) Yes, describe under DESCRIPTION OF OPERATIONS below <input type="checkbox"/> Y/N <input type="checkbox"/> N/A					<input type="checkbox"/> PER STATUTE <input type="checkbox"/> OTHER EL - EACH ACCIDENT \$ _____ EL DISEASE - LA EMPLOYEE \$ _____ EL DISEASE - POLICY LIMIT \$ _____

<b>A</b>	<b>Medical Malpractice</b>	690025	04/01/2017	04/01/2018	See Below
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DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)  
 Evidence of Modified Claims Made Coverage  
 Limits of Liability: \$2,000,000 per Occurrence; \$6,000,000 Annual Aggregate  
 Khaled Sorour, M.D. is covered under class 80199 - Anesthesiology.

<b>CERTIFICATE HOLDER</b>  Insured	<b>CANCELLATION</b>  SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.
	AUTHORIZED REPRESENTATIVE 