



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

Annual Report for the year: 2018
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 126207		2. Exact name of the Corporation Santiago Medical Group, Inc.			
3. Principal Office Address 967 Mineral Spring Avenue			City North Providence	State RI	Zip 02904
4. NAICS Code 621111		6. Brief description of the character of business conducted in Rhode Island The practice of medicine and other lawful business			
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 Miguel Fuentes, MD			Vice-President Name Teresa Jeraldo, MD		
Street Address 26 Alumni Avenue			Street Address 26 Alumni Avenue		
City Providence	State RI	Zip 02906	City Providence	State RI	Zip 02906
Secretary Name Miguel Fuentes, MD			Treasurer Name Teresa Jeraldo, MD		
Street Address 26 Alumni Avenue			Street Address 26 Alumni Avenue		
City Providence	State RI	Zip 02906	City Providence	State RI	Zip 02906
8. List ALL directors (names and addresses) Check the box to indicate an attachment <input type="checkbox"/>					
Director Name Miguel Fuentes, MD			Director Name		
Street Address 26 Alumni Avenue			Street Address		
City Providence	State RI	Zip 02906	City	State	Zip
Director Name			Director Name		
Street Address			Street Address		
City	State	Zip	City	State	Zip
9. Shares Authorized 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
			200	Common	2.00
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 <i>Miguel Fuentes, M.D.</i>				Date <i>2/5/18</i>	
Signature of Authorized Representative <i>[Signature]</i>				FILED	

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

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