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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	2. Exact name of the Corporation
1558	**Attleboro-Cumberland Oral Surgeons, Inc.**

3. Principal Office Address	City	State	Zip
103 Commonwealth Avenue	**Attleboro Falls**	**MA**	**02763**

4. NAICS Code	6. Brief description of the character of business conducted in Rhode Island
621210	**Practice of dentistry and oral surgeons.**
5. State of Incorporation: **Rhode Island**	

7. List ALL officers (names and addresses) — Check the box to indicate an attachment ☐

President Name **Mark D. Schenkman**			Vice-President Name **None**		
Street Address **170 Paine Road**			Street Address		
City **North Attleboro**	State **MA**	Zip **02760**	City	State	Zip
Secretary Name **Mark D. Schenkman**			Treasurer Name **Mark D. Schenkman**		
Street Address **170 Paine Road**			Street Address **170 Paine Road**		
City **North Attleboro**	State **MA**	Zip **02760**	City **North Attleboro**	State **MA**	Zip **02760**

8. List ALL directors (names and addresses) — Check the box to indicate an attachment ☐

Director Name **Mark D. Schenkman**			Director Name		
Street Address **170 Paine Road**			Street Address		
City **North Attleboro**	State **MA**	Zip **02760**	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 ☐

NUMBER OF SHARES	CLASS/SERIES	PAR VALUE
2000	**COMMON**	**NO PAR VALUE**

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: **Mark D. Schenkman, President**

Date: 3/7/18

Signature of Authorized Representative: MDS

SIGN DOCUMENT HERE

FILED
MAR 15 2018
BY 290109503 4
DS

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

FORM 630 - Revised: 02/2017