



STATE OF RHODE ISLAND
AND PROVIDENCE PLANTATIONS
Office of the Secretary of State

Matthew A. Brown, Secretary of State
Corporations Division
100 North Main Street, Providence, RI 02903-1333
401.222.3040

LIMITED LIABILITY COMPANY ANNUAL REPORT FOR THE YEAR 2005

Filing Period: September 1 - November 1 • Filing Fee: \$50.00

(FORM MUST BE TYPED OR PRINTED IN BLACK)

1. ID No. 126507		2. Exact name of the limited liability company HeadacheFree, LLC			
3. State of Formation RHODE ISLAND		4. Brief description of the character of the business which is actually conducted in Rhode Island SALE OF DIETARY SUPPLEMENTS			
5. Principal office address 227 CENTERVILLE ROAD		City WARWICK	State RI	Zip 02886-	
6. MAILING ADDRESS OF LIMITED LIABILITY COMPANY AND NAME OR TITLE OF CONTACT PERSON:					
Contact Name GARY L'EUROPA, M.D.			Contact Title .		
Street Address 227 CENTERVILLE ROAD		City WARWICK	State RI	Zip 02886-	
7. NAME AND ADDRESS OF EACH MANAGER OF THE LIMITED LIABILITY COMPANY, IF APPLICABLE: FILL IN SPACES BEFORE USING ATTACHMENTS ("X" BOX FOR ATTACHMENT) <input type="checkbox"/> ANY MODIFICATIONS TO MANAGERS REQUIRES FILING OF AMENDMENT. R.I.G.L. 7-16-12 (a) (2) / 7-16-52					
Manager Name GARY L'EUROPA, M.D.			*Manager Name .		
Street Address 227 CENTERVILLE ROAD			*Street Address .		
City WARWICK	State RI	Zip 02886	*City .	*State .	*Zip .
Manager Name .			*Manager Name .		
Street Address .			*Street Address .		
City .	State .	Zip .	*City .	*State .	*Zip .
8. RESIDENT AGENT IN RHODE ISLAND - DO NOT ALTER - Changes require filing of Form 642 - R.I.G.L. 7-16-11					
Agent Name CYNTHIA J. WARREN			Address 56 EXCHANGE TERRACE		
Address .		City PROVIDENCE	Zip 02903-		

This report must be signed in ink by an authorized person pursuant to 7-16-66.



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File Date _____

Check No. NOV 02 2005

By: KMC

FOR SECRETARY OF STATE USE ONLY A81301

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.

Signature of Authorized Person _____ Date 10/31/05

GARY L'EUROPA, M.D.
Print or Type Name of Authorized Person



STATE OF RHODE ISLAND
AND PROVIDENCE PLANTATIONS
Office of the Secretary of State

Matthew A. Brown, Secretary of State
Corporations Division
100 North Main Street, Providence, RI 02903-1335
401.222.3040

LIMITED LIABILITY COMPANY ANNUAL REPORT FOR THE YEAR 2004

Filing Period: September 1 - November 1 • Filing Fee: \$50.00

(FORM MUST BE TYPED OR PRINTED IN BLACK)

1. ID No. 126507		2. Exact name of the limited liability company HeadacheFree, LLC			
3. State of Formation Rhode Island		4. Brief description of the character of the business which is actually conducted in Rhode Island Sale of dietary supplements			
5. Principal office address 227 Centerville Road		City Warwick	State Rhode Island	Zip 02886	
6. MAILING ADDRESS OF LIMITED LIABILITY COMPANY AND NAME OR TITLE OF CONTACT PERSON:					
Contact Name Gary L'Europa, M.D.		Contact Title Manager			
Street Address 227 Centerville Road		City Warwick	State Rhode Island	Zip 02886	
7. NAME AND ADDRESS OF EACH MANAGER OF THE LIMITED LIABILITY COMPANY, IF APPLICABLE					
FILL IN SPACES BEFORE USING ATTACHMENTS (X) BOX FOR ATTACHMENT <input type="checkbox"/>					
ANY MODIFICATIONS TO MANAGERS REQUIRES FILING OF AMENDMENT R.I.G.L. 7-16-12 (b) (2) 7-16-52					
Manager Name Gary L'Europa, M.D.		*Manager Name			
Street Address 227 Centerville Road		*Street Address			
City Warwick	State Rhode Island	Zip 02886	City	State	Zip
Manager Name		*Manager Name			
Street Address		*Street Address			
City	State	Zip	City	State	Zip
8. RESIDENT AGENT IN RHODE ISLAND -DO NOT ALTER- Changes require filing of Form 642 - R.I.G.L. 7-16-11					
Agent Name Cynthia J. Warren, Esq.		Address Cameron & Mittleman LLP			
Address 56 Exchange Terrace		City Providence, RI	Zip 02903		

05 FEB 17 2005
SECRETARY OF STATE
CORPORATIONS DIVISION
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FILED

FEB 17 2005

By AME
51584

This report must be signed in ink by an authorized person pursuant to 7-16-66.



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File Date _____
Check No. _____
By _____
FOR SECRETARY OF STATE USE ONLY

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.

Signature of Authorized Person _____ Date 02/16/05
Gary L'Europa, M.D.
Print or Type Name of Authorized Person



LIMITED LIABILITY COMPANY ANNUAL REPORT FOR THE YEAR 2003

Filing Period: September 1 - November 1 • Filing Fee: \$50.00

(FORM MUST BE TYPED OR PRINTED IN BLACK)

1. ID No. 126507		2. Exact name of the limited liability company HeadacheFree, LLC			
3. State of Formation Rhode Island		4. Brief description of the character of the business which is actually conducted in Rhode Island Sale of dietary supplements			
5. Principal office address 227 Centerville Road		City Warwick	State Rhode Island	Zip 02886	
6. MAILING ADDRESS OF LIMITED LIABILITY COMPANY AND NAME OR TITLE OF CONTACT PERSON:					
Contact Name Gary L'Europa, M.D.		Contact Title Manager			
Street Address 227 Centerville Road		City Warwick	State Rhode Island	Zip 02886	
7. NAME AND ADDRESS OF EACH MANAGER OF THE LIMITED LIABILITY COMPANY, IF APPLICABLE: FILL IN SPACES BEFORE USING ATTACHMENTS (X) BOX FOR ATTACHMENT <input type="checkbox"/> ANY MODIFICATIONS TO MANAGERS REQUIRES FILING OF AMENDMENT, R.I.G.L. 7-16-12 (a) (2) / 7-16-52					
Manager Name Gary L'Europa, M.D.		*Manager Name			
Street Address 227 Centerville Road		*Street Address			
City Warwick	State Rhode Island	Zip 02886	City	State	Zip
*Manager Name		*Manager Name			
*Street Address		*Street Address			
City	State	Zip	City	State	Zip
8. RESIDENT AGENT IN RHODE ISLAND - DO NOT ALTER. Changes require filing of Form 642 - R.I.G.L. 7-16-11					
Agent Name Cynthia J. Warren, Esq.		Address Cameron & Mittleman LLP			
Address 56 Exchange Terrace		City Providence, RI	Zip 02903		

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SECRETARY OF STATE
CORPORATIONS DIV.

FILED

FEB 17 2005

By AME
57584

This report must be signed in ink by an authorized person pursuant to 7-16-66.



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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.

Signature of Authorized Person _____ Date 02/16/05

Gary L'Europa, M.D.
Print or Type Name of Authorized Person

File Date _____
Check No. _____
By: _____
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