



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

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 SECRETARY OF STATE
 CORPORATIONS DIV
 2018 MAY -3 AM 10:54

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 130438		2. Exact name of the Corporation DENTAL REPLACEMENTS, INC.			
3. Principal Office Address 9 BEACH DRIVE		City LITTLE COUPON	State R.I.	Zip 02837	
4. NAICS Code 561230		6. Brief description of the character of business conducted in Rhode Island TEMPORARY STAFFING PLACEMENTS FOR DENTAL OFFICES			
5. State of Incorporation MA.					
7. List ALL officers (names and addresses)					Check the box to indicate an attachment <input type="checkbox"/>
President Name STEVEN D. ROUSEY		Vice-President Name STEVEN D. ROUSEY			
Street Address 9 BEACH DR.		Street Address 9 BEACH DR.			
City LITTLE COUPON	State R.I.	Zip 02837	City LITTLE COUPON	State R.I.	Zip 02837
Secretary Name DAIRICA B. ROUSEY		Treasurer Name STEVEN D. ROUSEY			
Street Address 9 BEACH DR.		Street Address 9 BEACH DR.			
City LITTLE COUPON	State R.I.	Zip 02837	City LITTLE COUPON	State R.I.	Zip 02837
8. List ALL directors (names and addresses)					Check the box to indicate an attachment <input type="checkbox"/>
Director Name DAIRICA B. ROUSEY		Director Name STEVEN D. ROUSEY			
Street Address 9 BEACH DR.		Street Address 9 BEACH DR.			
City LITTLE COUPON	State R.I.	Zip 02837	City LITTLE COUPON	State R.I.	Zip 02837
Director Name N/A		Director Name N/A			
Street Address		Street Address			
City	State	Zip	City	State	Zip
9. Shares Authorized 15000		10. Shares Issued			
This information is currently of record in the Department of State. Changes require an additional filing.		NUMBER OF SHARES		CLASS/SERIES	PAR VALUE
		1000		COMMON	NO PAR
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 [Signature]					Date 4/27/18
Signature of Authorized Representative [Signature] SIGN DOCUMENT HERE					

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

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 FORM 630 - Revised: 10/2017