



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

Annual Report for the year: 2019
 Corporation

- Filing period: January 1 - March 1
- Filing Fee: \$50.00
- Penalty: Additional \$25.00 fee if form is not filed by April 1.

FILED STAMP

MAR 04 2019

5728 DS

1. Entity ID Number 795196		2. Exact name of the Corporation SAKONNET EYE CARE, INC.		BY <u><i>5728 DS</i></u>	
3. Principal Office Address 811 AQUIDNECK AVENUE			City MIDDLETOWN	State RI	Zip 02842
4. NAICS Code <i>WAMI</i> 62 - Health Care and Social As		6. Brief description of the character of business conducted in Rhode Island OPTOMETRY			
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 DR. KIRSTEN M.W. HEALEY, O.D.			Vice-President Name DR. KIRSTEN M.W. HEALEY, O.D.		
Street Address 811 AQUIDNECK AVENUE			Street Address 811 AQUIDNECK AVENUE		
City MIDDLETOWN	State RI	Zip 02842	City MIDDLETOWN	State RI	Zip 02842
Secretary Name DR. KIRSTEN M.W. HEALEY, O.D.			Treasurer Name DR. KIRSTEN M.W. HEALEY, O.D.		
Street Address SEE ABOVE			Street Address SEE ABOVE		
City	State	Zip	City	State	Zip
8. List ALL directors (names and addresses) Check the box to indicate an attachment <input type="checkbox"/>					
Director Name NONE			Director Name		
Street Address			Street Address		
City	State	Zip	City	State	Zip
Director Name			Director Name		
Street Address			Street Address		
City	State	Zip	City	State	Zip
9. Shares Authorized			10. Shares Issued Check the box to indicate an attachment <input type="checkbox"/>		
This information is currently of record in the Department of State. Changes require an additional filing.			NUMBER OF SHARES	CLASS/SERIES	PAR VALUE
			0	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				Date <u><i>2/25/2019</i></u>	
Signature of Authorized Representative				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