



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

148 W. River Street
Providence, RI 02904-2615
401.222.3040

LIMITED LIABILITY COMPANY ANNUAL REPORT FOR THE YEAR 2020

Filing Period: September 1 - November 1 • **Filing Fee:** \$50.00* • **THIS REPORT MUST BE TYPED OR PRINTED LEGIBLY IN BLACK INK.**

*In accordance with R.I.G.L. 7-16-66 (d), each limited liability company failing or refusing to file its annual report within thirty (30) days after the time prescribed by law (R.I.G.L. 7-16-66 (b&c)) is subject to a penalty fee of \$25.00.

1. ID No. 001661411		2. Exact name of the limited liability company Shaghalian Family Dental, LLC			3. NAICS Code 621210	
4. Brief description of the character of the business which is actually conducted in Rhode Island dental practice					5. State of Formation Rhode Island	
6. Principal office address 1002 Pawtucket Avenue			City Rumford	State RI	Zip 02916	
7. MAILING ADDRESS OF LIMITED LIABILITY COMPANY AND NAME OR TITLE OF CONTACT PERSON:						
Contact Name Justin W. Shaghalian, DMD			Contact Title Manager			
Street Address 1002 Pawtucket Avenue			City Rumford	State RI	Zip 02916	
8. NAME AND ADDRESS OF EACH MANAGER OF THE LIMITED LIABILITY COMPANY, IF APPLICABLE - DO NOT LIST MEMBERS FILL IN SPACES BEFORE USING ATTACHMENTS ("X" BOX FOR ATTACHMENT) <input type="checkbox"/>						
Manager Name Justin W. Shaghalian, DMD			Manager Name			
Street Address 1002 Pawtucket Avenue			Street Address			
City Rumford	State RI	Zip 02916	City	State	Zip	
Manager Name			Manager Name			
Street Address			Street Address			
City	State	Zip	City	State	Zip	
9. RESIDENT AGENT IN RHODE ISLAND						
This information is currently of record in the Office of the Secretary of State. Changes require filing of Form 642 – R.I.G.L. 7-16-11 Orson and Brusini Ltd.						

FILED

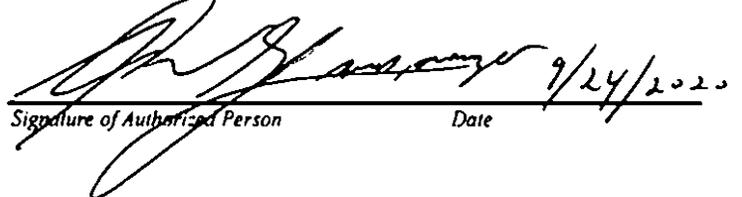
KJM

OCT 08 2020

This report must be executed by an authorized person pursuant to R.I.G.L. 7-16-66 (b).

BY 1232

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 **9/24/2020**

Justin W. Shaghalian, DMD, Manager

Print or Type Name of Authorized Person

File Date _____
Check No. _____
By: _____
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