



State of Rhode Island

## Department of State - Business Services Division

Annual Report for the year: 2020

## Limited Liability Company

→ Filing period: September 1 - November 1

→ Filing Fee: \$50.00

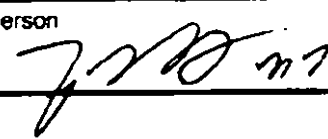
→ Penalty: Additional \$25.00 fee if form is not filed by December 1.

FILED

NOV 16 2020

BY

185 LMS

|   |       |  |                         |                 |                          |
|---|-------|--|-------------------------|-----------------|--------------------------|
| 1. Entity ID Number<br>313389   |       | 2. Exact name of the Limited Liability Company<br>East Side Urgent Care, LLC   |                         |                 |                          |
| 3. NAICS Code<br>621498   |       | 4. Brief description of the character of business conducted in Rhode Island<br>Providing urgent care medical services. |                         |                 |                          |
| 5. State of Formation<br>Rhode Island   |       |  |                         |                 |                          |
| 6. Principal Office Address<br>1195 North Main Street   |       | City<br>Providence   |                         | State<br>RI     | Zip<br>02904             |
| 7. Mailing Address of Limited Liability Company and Name or Title of Contact Person   |       |  |                         |                 |                          |
| Contact Name<br>Frank D'Alessandro, M.D.  |       |  | Contact Title<br>Member |                 |                          |
| Street Address<br>2130 Mendon Road  |       |  | City<br>Cumberland      |                 | State<br>RI Zip<br>02864 |
| 8. List ALL managers (names and addresses) of the Limited Liability Company, IF APPLICABLE - DO NOT LIST MEMBERS  |       |  |                         |                 |                          |
| Manager Name  |       |  | Manager Name            |                 |                          |
| Street Address  |       |  | Street Address          |                 |                          |
| City  | State | Zip  | City                    | State           | Zip                      |
| Manager Name  |       |  | Manager Name            |                 |                          |
| Street Address  |       |  | Street Address          |                 |                          |
| City  | State | Zip  | City                    | State           | Zip                      |
| Check the box to indicate an attachment <input type="checkbox"/>  |       |  |                         |                 |                          |
| 9. The Resident Agent information currently of record with the RI Department of State is accurate. Changes require filing Form 642.   |       |  |                         |                 |                          |
| <i>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.</i> |       |  |                         |                 |                          |
| Name of Authorized Person<br>Frank D'Alessandro, M.D.   |       |  |                         | Date<br>11/3/20 |                          |
| Signature of Authorized Person<br>   |       |  |                         |                 |                          |

## MAIL TO:

Division of Business Services

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