



State of Rhode Island

Department of State - Business Services Division

Annual Report for the year: **2022**

Corporation

→ Filing period: February 1 - May 1


→ Filing Fee: \$50.00

→ Penalty: Additional \$25.00 fee if form is not filed by May 31.

FILED

MAR 06 2023

BY 108ES

1. Entity ID Number 001746322		2. Exact name of the Corporation BrainWaves Neuro Restoration Center, Inc.			
3. Principal Office Address 400 Bald Hill Road		City Warwick		State RI	Zip 02886
4. NAICS Code 621112		6. Brief description of the character of business conducted in Rhode Island Mental Health Services			
5. State of Incorporation RI					
7. List ALL officers (names and addresses) Check the box to indicate an attachment <input type="checkbox"/>					
President Name Mark Turshen, MD.			Vice-President Name Mark Turshen, MD.		
Street Address 45 Bunker Hill Lane			Street Address 45 Bunker Hill Lane		
City East Greenwich	State RI	Zip 02818	City East Greenwich	State RI	Zip 02818
Secretary Name Mark Turshen, MD.			Treasurer Name Mark Turshen, MD.		
Street Address 45 Bunker Hill Lane			Street Address 45 Bunker Hill Lane		
City East Greenwich	State RI	Zip 02818	City East Greenwich	State RI	Zip 02818
8. List ALL directors (names and addresses) Check the box to indicate an attachment <input type="checkbox"/>					
Director Name Mark Turshen, MD.			Director Name		
Street Address 45 Bunker Hill Lane			Street Address		
City East Greenwich	State RI	Zip 02818	City	State	Zip
Director Name			Director Name		
Street Address			Street Address		
City	State	Zip	City	State	Zip
9. Shares Authorized 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.			10. Shares Issued Check the box to indicate an attachment <input type="checkbox"/>		
			NUMBER OF SHARES 1,000	CLASS/SERIES Common	PAR VALUE 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 Mark Turshen, MD				Date 3/1/23	
Signature of Authorized Representative 					

MAIL TO:

Division of Business Services

148 W River Street, Providence, Rhode Island 02904-2615

Phone: (401) 222-3040

Website: www.sos.ri.gov

FORM 630 - Revised: 2/2023