



State of Rhode Island
Department of State - Business Services Division

Annual Report for the year: 2024

Corporation _____

- Filing period: February 1 - May 1
- Filing Fee: \$50.00
- Penalty: Additional \$25.00 fee if form is not filed by May 31.

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1. Entity ID Number 000086739	2. Exact name of the Corporation Blackstone Valley Pediatric & Adolescent Medicine, PC.
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3. Principal Office Address 2 MEEHAN LANE	City CUMBERLAND	State RI	Zip 02864
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4. NAICS Code 541990	6. Brief description of the character of business conducted in Rhode Island TO PROVIDE MEDICAL SERVICES AND ACTIVITIES RELATED THERETO.
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 MAUREEN A. CROTTY, MD			Vice-President Name ALEXANDER LEE, MD		
Street Address 2 MEEHAN LANE			Street Address 2 MEEHAN LANE		
City CUMBERLAND	State RI	Zip 02864	City CUMBERLAND	State RI	Zip 02864
Secretary Name MAUREEN A. CROTTY, MD			Treasurer Name ALEXANDER LEE, MD		
Street Address 2 MEEHAN LANE			Street Address 2 MEEHAN LANE		
City CUMBERLAND	State RI	Zip 02864	City CUMBERLAND	State RI	Zip 02864

8. List ALL directors (names and addresses) Check the box to indicate an attachment <input type="checkbox"/>					
Director Name			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.	NUMBER OF SHARES	CLASS/SERIES	PAR VALUE
Changes require an additional filing.	1,000.00	CNP	\$0.00

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 MAUREEN A. CROTTY, MD	Date 3/8/24
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Signature of Authorized Representative 	FILED
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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 04/2023