



**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.

FILED STAMP
APR 10 2024
 BY 3910

1. Entity ID Number 000101903		2. Exact name of the Corporation Carine M. Leconte, M.D., Inc.			
3. Principal Office Address 1150 Reservoir Avenue, Suite 205			City Cranston	State RI	Zip 02920
4. NAICS Code 621112		6. Brief description of the character of business conducted in Rhode Island To carry on all business that a physician licensed to practice medicine in the State of Rhode Island might be involved.			
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 Carine M. Leconte			Vice-President Name Carine M. Leconte		
Street Address 1150 Reservoir Avenue, Suite 205			Street Address 1150 Reservoir Avenue, Suite 205		
City Cranston	State RI	Zip 02920	City Cranston	State RI	Zip 02920
Secretary Name Carine M. Leconte			Treasurer Name Carine M. Leconte		
Street Address same as above			Street Address same as 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			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
		600	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 Carine M. Leconte, M.D., President					Date 4/11/24
Signature of Authorized Representative 					

MAIL TO:
 Division of Business Services
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 Website: www.sos.ri.gov