



State of Rhode Island

Department of State - Business Services Division

FILED

MAY 02 2024

Annual Report for the year: 2024

Non-Profit Corporation

→ Filing period: February 1 - May 1

→ Filing Fee: \$20.00

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

BY _____

1. Entity ID Number 000950705		2. Exact name of the Corporation Rhode Island Association of Oral and Maxillofacial Surgeons			
3. State of Incorporation Rhode Island		5. Brief description of the character of business conducted in Rhode Island To contribute to the public health and welfare by advancement of the specialty of oral and maxillofacial surgery by fostering programs of education, etc.			
4. NAICS Code 813920 - Professional Organizati					
6. Principal Office Address 875 CENTERVILLE ROAD BLDG 4 STE 12		City Warwick		State RI	Zip 02886
7. List ALL officers (names and addresses) Check the box to indicate an attachment <input type="checkbox"/>					
President Name Frank Paletta MD DMD FAC			Vice-President Name Mo Banki		
Street Address 243 Jefferson Blvd			Street Address 243 Jefferson Blvd		
City Warwick	State RI	Zip 02888	City Warwick	State RI	Zip 02888
Secretary Name E. Joseph Domingo			Treasurer Name Frederick Hartman DMD		
Street Address 600 Wampanoag Trail			Street Address 600 Wampanoag Trail		
City East Providence	State RI	Zip 02915	City East Providence	State RI	Zip 02915
8. List ALL directors (names and addresses). RI Corporations MUST list at least THREE directors. Check the box to indicate an attachment <input type="checkbox"/>					
Director Name Frank Paletta MD DMD FAC			Director Name Mo Banki		
Street Address 243 Jefferson Blvd			Street Address 243 Jefferson Blvd		
City Warwick	State RI	Zip 02915	City Warwick	State RI	Zip 02915
Director Name E. Joseph Domingo			Director Name Frederick Hartman DMD		
Street Address 600 Wampanoag Trail			Street Address 600 Wampanoag Trail		
City East Providence	State RI	Zip 02915	City East Providence	State RI	Zip 02915
9. The Registered Agent information of record with the RI Department of State is accurate. Changes require filing Form 641.					
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.					
This report must be signed by either the President, Vice-President, Secretary, Assistant Secretary, Treasurer, duly Authorized Representative, Receiver or Trustee.					
Name of Officer/Authorized Representative Dr. Frederick A. Hartman				Date 4-25-24	
Signature of Officer/Authorized Representative [Signature]					