



State of Rhode Island  
Department of State - Business Services Division

Annual Report for the year:  
Corporation

2025

REC'D RI SOS BSD  
25 MAY 28 PM 4:20:30

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

1. Entity ID Number 0001 32875		2. Exact name of the Corporation Robert C Impagliazzo, DMD, Inc			
3. Principal Office Address 5 Peckham Ave			City Woonsocket	State RI	Zip 02879
4. NAICS Code 621210		6. Brief description of the character of business conducted in Rhode Island Dental office			
5. State of Incorporation RI					
7. List ALL officers (names and addresses) <span style="float: right;">Check the box to indicate an attachment <input type="checkbox"/></span>					
President Name Robert C Impagliazzo			Vice-President Name		
Street Address 5 Peckham Ave			Street Address		
City Woonsocket	State RI	Zip 02879	City	State	Zip
Secretary Name			Treasurer Name		
Street Address			Street Address		
City	State	Zip	City	State	Zip
8. List ALL directors (names and addresses) <span style="float: right;">Check the box to indicate an attachment <input type="checkbox"/></span>					
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	
		100		0	
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. <b>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.</b>					
Name of Authorized Representative Robert C Impagliazzo DMD					Date 4/28/2025
Signature of Authorized Representative [Signature]					BY [Signature]

MAIL TO:  
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