



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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BUS. SVCS. DIV.
2025 JUN -9 A 11:51

1. Entity ID Number 001662639		2. Exact name of the Corporation QUALITY PHYSICAL THERAPY, INC.			
3. Principal Office Address 179 MAIN STREET			City STURBRIDGE	State MA	Zip 01566
4. NAICS Code 621340		6. Brief description of the character of business conducted in Rhode Island WELLNESS AND INJURY PREVENTION CONSULTATION.			
5. State of Incorporation MA					
7. List ALL officers (names and addresses) Check the box to indicate an attachment ☐					
President Name CHERYL WILBUR			Vice-President Name NONE		
Street Address 179 MAIN STREET			Street Address N/A		
City STURBRIDGE	State MA	Zip 01566	City N/A	State N/A	Zip N/A
Secretary Name CHERYL WILBUR			Treasurer Name CHERYL WILBUR		
Street Address 179 MAIN STREET			Street Address 179 MAIN STREET		
City STURBRIDGE	State MA	Zip 01566	City STURBRIDGE	State MA	Zip 01566
8. List ALL directors (names and addresses) Check the box to indicate an attachment ☐					
Director Name CHERYL WILBUR			Director Name NONE		
Street Address 179 MAIN STREET			Street Address N/A		
City STURBRIDGE	State MA	Zip 01566	City N/A	State N/A	Zip N/A
Director Name NONE			Director Name NONE		
Street Address N/A			Street Address N/A		
City N/A	State N/A	Zip N/A	City N/A	State N/A	Zip N/A
9. Shares Authorized		10. Shares Issued Check the box to indicate an attachment ☐			
This information is currently of record in the Department of State. Changes require an additional filing.		NUMBER OF SHARES CLASS/SERIES PAR VALUE			
		100		COMMON	NO PAR
		N/A		N/A	N/A
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 CHERYL WILBUR				Date ✓ 6/5/25	
Signature of Authorized Representative ✓ Cheryl Wilbur				FILED	

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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BY **00364**
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FORM 630- Revised 12/2023