



State of Rhode Island
Department of State - Business Services Division

Articles of Incorporation

Professional Service Corporation

→ Filing Fee: \$230.00 minimum

RECEIVED
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BUS SVCS DIV

2025 SEP 10 AM 8:50

The undersigned acting as incorporator(s) of a professional service corporation under

RIGL 7-5.1 and 7-1.2, adopt(s) the following Articles of Incorporation for such corporation:

1. The name of the corporation is:		
Monica Sheridan, MD, PC		
<input type="checkbox"/> Check if this a close corporation pursuant to RIGL 7-1.2-1701 of the General Laws, 1956, as amended.		
2. The profession to be practiced through the professional service corporation is:		
Medical Services		
3. The total number of shares which the corporation has the authority to issue is:		
<i>(Unless otherwise stated, all authorized shares are deemed to have a nominal or par value of \$0.01 per share.)</i>		
Total Authorized Shares (Number of Shares)	Class of Stock	Par Value Per Share
100	Common	
If you desire, you may include a statement of all or any of the designations and the power, preferences, and rights, including voting rights, and the qualifications, limitations, or restrictions of them which are permitted by the provisions of RIGL 7-1.2. State any provisions here <i>(optional)</i> : <div style="text-align: right;">Check the box to indicate an attachment <input type="checkbox"/></div>		
4. The name and address of the initial registered agent/office in Rhode Island is:		
Agent Name		
Monica Sheridan		
Street Address (<u>NOT</u> a P.O. Box)		
555 N Main Street #1233		
City/Town	State	Zip Code
Providence	RHODE ISLAND	02904

MAIL TO:

Division of Business Services

148 W. River Street, Providence, Rhode Island 02904-2615

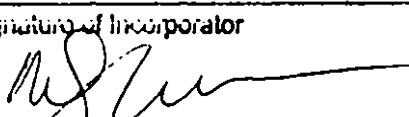
Phone: (401) 222-3040

Website: www.sos.ri.gov

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SEP 10 2025 8:50am

BY LKS 1345201

5. The corporation shall have perpetual existence until dissolved or terminated in accordance with RIGL 7-1.2.		
6. Additional provisions, if any, not inconsistent with RIGL 7-1.2 which the incorporators elect to have set forth in these Articles of Incorporation:		
Check the box to indicate an attachment <input type="checkbox"/>		
7. The name and address of each incorporator is:		
Name Monica Sheridan	Address 555 N Main Street #1233	
City/Town Providence	State RI	Zip Code 02904
Name	Address	
City/Town	State	Zip Code
Name	Address	
City/Town	State	Zip Code
8. Date when these Articles of Incorporation will be effective: CHECK ONE BOX ONLY		
<input checked="" type="checkbox"/> Date received (Upon filing)		
<input type="checkbox"/> Later effective date (Date must be no more than 90 days from the date of filing) _____		
9. Under penalty of perjury, I/we declare and affirm that I/we have examined these Articles of Incorporation, including any accompanying attachments, and that all statements contained herein are true and correct.		
Type or Print Name of Incorporator Monica Sheridan	Date 9/9/25	
<input checked="" type="checkbox"/> Signature of Incorporator 		
Type or Print Name of Incorporator	Date	
Signature of Incorporator		
Type or Print Name of Incorporator	Date	
Signature of Incorporator		

If you have any questions, please call us at (401) 222-3040, Monday through Friday, between 8:30 a.m. and 4:30 p.m., or email corporations@sos.ri.gov.



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
7/16/2025

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. IF SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Arthur J. Gallagher Risk Management Services, LLC 11550 Fuqua Street, Suite 205 Houston TX 77034	CONTACT NAME: Credentialing Team PHONE (A/C, No. Ext): 281-674-1420 FAX (A/C, No): 281-674-1460 E-MAIL: GSHIS@AJG.COM ADDRESS: _____
INSURED Sycamore Physician Contracting, LLC 200 Westside Sq. Ste 600 Huntsville, AL 35801	INSURER(S) AFFORDING COVERAGE INSURER A: Columbia Casualty Company INSURER B: _____ INSURER C: _____ INSURER D: _____ INSURER E: _____ INSURER F: _____

COVERAGES **CERTIFICATE NUMBER:** 1475713654 **REVISION NUMBER:** _____

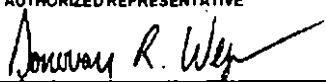
THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS

INSR LTR	TYPE OF INSURANCE	ADDL SUBR INSD WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR <input type="checkbox"/> _____ GEN'L AGGREGATE LIMIT APPLIES PER <input type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC <input type="checkbox"/> OTHER					EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$ \$
	AUTOMOBILE LIABILITY ANY AUTO OWNED AUTOS ONLY HIRED AUTOS ONLY SCHEDULED AUTOS NON-OWNED AUTOS ONLY					COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input type="checkbox"/> RETENTION \$					EACH OCCURRENCE \$ AGGREGATE \$ \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A If yes, describe under DESCRIPTION OF OPERATIONS below					PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/> E L EACH ACCIDENT \$ E L DISEASE - EA EMPLOYEE \$ E L DISEASE - POLICY LIMIT \$
A	Medical Prof Liability Type: Claims Made		HPP6081368427	7/17/2025	7/17/2026	Each Med Incident \$1,000,000 Aggregate Lim: \$3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Coverage is limited to work on behalf of Sycamore Physician Contracting, LLC. The insured organizations, insured professionals, insured paramedical(s) and other covered employees will share the insured organization limit of liability.
Monica Shendan
Insured Specialty: Emergency Medicine

CERTIFICATE HOLDER

CANCELLATION

TeamHealth / Sullivan County Community Hospital 2200 N Section St Sullivan IN 47882	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE 
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State of Rhode Island

Department of State | Office of the Secretary of State

Gregg M. Amore, *Secretary of State*

I, GREGG M. AMORE, Secretary of State of the State of Rhode Island,
hereby certify that this document, duly executed in accordance with the provisions
of Title 7 of the General Laws of Rhode Island, as amended, has been filed in this

office on this day:

September 10, 2025 08:50 AM

A handwritten signature in black ink that reads "Gregg M. Amore".

Gregg M. Amore
Secretary of State

