RI SOS Filing Number: 202580502800 Date: 11/21/2025 10:49:00 AM

RECD RIDOS BSD
25 NOV 21 AM 10:42:50

State of Rhode Island
Department of State - Business Services Division

Annual Report for the year: 2023
Corporation

→ 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 000273209	2. Exact name of the Corporation Medical Assisted Recovery Inc.

3. Principal Office Address	City	State	Zip
875 Centerville Road, Suite 5A	Warwick	RI	02886

4. NAICS Code 000062	6. Brief description of the character of business conducted in Rhode Island Medical Sevices
5. State of Incorporation Rhode Island	

7. List ALL officers (names and addresses) Check the box to indicate an attachment ☐

President Name: Sylvester Sviokla MD			Vice-President Name: Sylvester Sviokla MD		
Street Address: 875 Centerville Road, Suite 5A			Street Address: 875 Centerville Road, Suite 5A		
City: Warwick	State: RI	Zip: 02886	City: Warwick	State: RI	Zip: 02886
Secretary Name: Sylvester Sviokla MD			Treasurer Name: Sylvester Sviokla MD		
Street Address: 875 Centerville Road, Suite 5A			Street Address: 875 Centerville Road, Suite 5A		
City: Warwick	State: RI	Zip: 02886	City: Warwick	State: RI	Zip: 02886

8. List ALL directors (names and addresses) Check the box to indicate an attachment ☐

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
This information is currently of record in the Department of State.
Changes require an additional filing.

10. Shares Issued Check the box to indicate an attachment ☐

NUMBER OF SHARES	CLASS/SERIES	PAR VALUE
8,000	STK	$0.0100

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	Date
Sylvester Sviokla MD	11-21-25

Signature of Authorized Representative: Sylvester Sviokla MD

MAIL TO:
Division of Business Services
148 W. River Street, Providence, Rhode Island 02904-2615
Phone: (401) 222-3040
Website: www.sos.ri.gov

FILED
NOV 21 2025
BY KV N72MA
10:49AM

FORM 630- Revised: 10/2025