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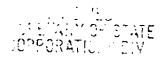
Department of State - Business Services Division

Annual Report for the year: 2017 Corporation 1

→ Filing period: January 1 - March 1

→ Filing Fee: \$50.00

→ Penalty: Additional \$25.00 fee if to



2019 APR -9 AH 11: 36

Penalty: Additional \$28 The state of the state o							
000159174		2 Exact name of the Corporation Diversified Clinical Services Inc					
3 Principal Office Address			City		State	Zip	
5220 Belfort RD STE 130			Jacksonv	ille	FL	32256	
4 NAICS Code	6. Brief desc	Brief description of the character of business conducted in Rhode Island					
541611		Medical Office Management Services					
5 State of Incorporation			00.7.003				
Delaware	1						
7. List ALL officers (names ar	nd addresses)			Check	the how to ind	icate on attachment [7]	
President Name David Bassin			Vice President Name Check the box to indicate an attachment □				
Street Address 5220 Belfort RD STE 130			Street Address				
City Jacksonville	State FL	Zip 32256	City		State	Žip	
Secretary Name Keith Koford			Treasurer Name Allan Woodward				
Street Address 5220 Belfort RD STE 130			Street Address 5220 Belfort RD STE 130				
City Jacksonville	State FL	^{Zip} 32256	City Jacksonville		State FL	^{Zip} 32256	
8 List ALL directors (names a	and addresses)			Check	the box to indi	icate an attachment	
Director Name David Bassin			Director Name				
Street Address 5220 Belfort RD STE 130			Street Address				
City Jacksonville	State FL	^{Zıp} 32256	City		State	Zip	
Director Name			Director Nam	ne	<u>l</u>		
Street Address							
Sireet Address			Street Address				
City	State	Zip	City	<u> </u>	State	Zip	
9 Shares Authorized		10. Shares Issued		Check	the box to indi	cate an attachment	
This information is currently of	record in the	NUMBER O	F SHARES	CLASS/SERIL	S S	PAR VA. JE	
Department of State. Changes require an additional filing.		10000		COMMON	MON 1.00		
11. This report must be execu	ted on behalf of the	corporation by an a	authorized repre	esentative If the corn	oration is in the	hands of a receiver or	
<u>trustee, this report must be ex</u>	ecuted on behalf of	the corporation by	the receiver or t	trustee		1	
Under penalty of perjury, I o statements, and that all stat	leclare and affirm t	hat I have examin	ed this report,	including any accor	npanying sch	edules and	
statements, and that all statements contained herein are true and correct. Name of Authorized Representative					Date		
Allan Woodward			Date				
Signature of Authorized Repre	esentetive	SIGN DO	CUMENT HERE	<u> </u>	_1	 .	
John 1					<u>. </u>		

MAIL TO:

Division of Business Services

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

Phone: (401) 222-3040 Website: www.sos.ri.gov トルトロ

APR 09 2019

FORM 630 - Revised: 10/2017