



State of Rhode Island
Department of State - Business Services Division

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Articles of Incorporation

Professional Service Corporation


→ Filing Fee: \$230.00 minimum

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: PROVIDENCE DENTAL 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: DENTISTRY		
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
10000	NON PAR	
_____	_____	_____
_____	_____	_____
_____	_____	_____
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 AH DENTAL PC		
Street Address (NOT a P.O. Box) 262 HARRISVILLE MAIN ST		
City/Town HARRISVILLE	State RHODE ISLAND	Zip Code 02830

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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5. The corporation shall have perpetual existence until dissolved or terminated in accordance with RIGL <u>7-1.2</u> .		
6. Additional provisions, if any, not inconsistent with RIGL <u>7-1.2</u> 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 ALAA AHMED	Address 5 KERRIGAN WAY	
City/Town WOBURN	State MA	Zip Code 01801
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 ALAA AHMED	Date 01/29/2024	
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)
8/25/2023

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 Integrated Insurance Solutions, LLC 1881 Worcester Road Suite 101 Framingham MA 01701		CONTACT NAME: PHONE (A/C, No, Ext): 508-370-0002 FAX (A/C, No): 508-370-0758 E-MAIL: ADDRESS:	
INSURED Alaa Islam Ahmed, D.M.D. 2001 Beacon St Suite 300 Brighton MA 02135		INSURER(S) AFFORDING COVERAGE NAIC # INSURER A : Coverys 14160 INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :	

COVERAGES **CERTIFICATE NUMBER: 598249703** **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 WYD	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 GENL AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <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 <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> 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 RETENTION \$					EACH OCCURRENCE \$ AGGREGATE \$ \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? <input type="checkbox"/> Y <input checked="" type="checkbox"/> N/A If yes, describe under DESCRIPTION OF OPERATIONS below					PER STATUTE OTH-ER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
A	Professional Liability Occurrence Form		001MA000023710	8/22/2023	8/22/2024	Limit \$1,000,000 Aggregate \$3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Subject to policy terms, forms and conditions.

CERTIFICATE HOLDER Proof of Insurance	CANCELLATION 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



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:

January 30, 2024 01:48 PM

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

Gregg M. Amore
Secretary of State

