| DATE | DOCUMENT ID | DESCRIPTION | FILING | EXPED | PENALTY | CERT | COPY |
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| 07/21/2022 | 202220201072 | BIENNIAL REPORT OF PROFESSIONAL ASSOCIATION (22A) | 25.00 | | | | 0 |

**Receipt**

This is not a bill. Please do not remit payment.

**KELLY GREANEY**
**265 BROOKVIEW CENTRE WAY, SUITE 400**
**KNOXVILLE, TN, 37919**

# STATE OF OHIO
# CERTIFICATE

## Ohio Secretary of State, Frank LaRose

**1975025**

It is hereby certified that the Secretary of State of Ohio has custody of the business records for

**HOSPITAL MEDICINE ASSOCIATES OF OHIO, PROFESSIONAL CORPORATION**

and, that said business records show the filing and recording of:

| Document(s) | Document No(s): |
|---|---|
| **BIENNIAL REPORT OF PROFESSIONAL ASSOCIATION** | **202220201072** |

**Effective Date: 07/21/2022**

United States of America
State of Ohio
Office of the Secretary of State

Witness my hand and the seal of the Secretary of State at Columbus, Ohio this 21st day of July, A.D. 2022.

**Ohio Secretary of State**

Form 520 Prescribed by:

Date Electronically Filed: 7/21/2022

Toll Free: 877.767.3453 | Central Ohio: 614.466.3910

OhioSoS.gov | business@OhioSoS.gov

File online or for more information: OhioBusinessCentral.gov

# Biennial Report

## (Domestic, Professional Association, Domestic or Foreign LLP)

## Filing Fee: $25

### Form Must Be Typed

**CHECK ONLY ONE (1) Box**

(1) ☒ 2022 Indicate Year — Biennial Report of Professional Association (102-YRA) (even-numbered years)

List Profession: MEDICAL

(2) ☐ Indicate Year — Biennial Report of Limited Liability Partnership (103-YRL) (odd-numbered years)

If foreign limited liability partnership, provide jurisdiction of formation:

Name of Entity: HOSPITAL MEDICINE ASSOCIATES OF OHIO, PROFESSIONAL CORPORATION

Charter or Registration Number: 1975025

**Complete the information in this section if box (1) is checked**

**Shareholders of Professional Association**

Authenticating this form constitutes a certification that all the below listed shareholders are duly licensed or otherwise legally authorized to render the professional services in this state in the profession that is listed above.

| Name | Address |
|---|---|
| WILLIAM COLE, MD | 265 BROOKVIEW CENTRE WAY, STE 400 KNOXVILLE T |
| | |
| | |
| | |
| | |
| | |

**Complete the applicable information in this section if box (2) is checked**

Address of the partnership's chief executive office:

Mailing Address

City | State | Zip Code

If the chief executive office is not in Ohio, the address of any office of the partnership in Ohio:

Mailing Address

City | State | Zip Code

If the partnership does not have an office in Ohio, the name and address of the partnership's current agent for service of process:

Name of Agent

Mailing Address

City | State | Zip Code

By signing and submitting this form to the Ohio Secretary of State, the undersigned hereby certifies that he or she has the requisite authority to execute this document.

**Required**
Report must be signed by an officer of the professional association or partner or authorized representative of the partnership.

If authorized representative is an individual, then they must sign in the "signature" box and print their name in the "Print Name" box.

JOHN R STAIR
Signature

By (if applicable)

Print Name

If authorized representative is a business entity, not an individual, then please print the business name in the"signature" box, an authorized representative of the business entity must sign in the "By" box and print their name in the "Print Name" box.