



DATE	DOCUMENT ID	DESCRIPTION	FILING	EXPED	CERT	COPY
06/24/2024	202417303010	BIENNIAL REPORT OF PROFESSIONAL ASSOCIATION (18A)	25.00	0.00	0.00	0.00

Receipt

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

HARTVILLE INTERNAL MEDICINE PA
855 W MAPLE ST
HARTVILLE, OH 44632

STATE OF OHIO CERTIFICATE

Ohio Secretary of State, Frank LaRose
1241544

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

HARTVILLE INTERNAL MEDICINE, P.A., INC.

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

Document(s)

BIENNIAL REPORT OF PROFESSIONAL ASSOCIATION

Effective Date: 06/21/2024

Document No(s):

202417303010



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
24th day of June, A.D. 2024.

Ohio Secretary of State

Form 520 Prescribed by:



Toll Free: 877.787.3453

Central Ohio: 614.466.3910

OhioSoS.govbusiness@OhioSoS.govFile online or for more information: OhioBusinessCentral.gov

Mail this form to one of the following:

Regular Filing (non expedite)

P.O. Box 788

Columbus, OH 43216

Expedite Filing (Two business day processing time.
Requires an additional \$100.00)

P.O. Box 1390

Columbus, OH 43216

For screen readers, follow instructions located at this path.

Biennial Report
(Domestic, Professional Association, Domestic or Foreign LLP)
Filing Fee: \$25
Form Must Be Typed

2024 JUN 21 PM 12:49

CHECK ONLY ONE (1) Box

(1) ☐ 2018 Biennial Report
Indicate Year of Professional
Association (102-YRA)
(even-numbered years)

List Profession

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

If foreign limited liability
partnership, provide
jurisdiction of formation

Name of Entity Charter or Registration Number

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

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

OH
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

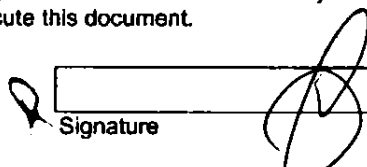
State

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.



Signature

By (if applicable)

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

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.