



DATE	DOCUMENT ID	DESCRIPTION	FILING	EXPED	CERT	COPY
08/30/2024	202424203198	BIENNIAL REPORT OF PROFESSIONAL ASSOCIATION (24A)	25.00	0.00	0.00	0.00

Receipt

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

HARTVILLE INTERNAL MEDICINE INC.
ATTN: AMIN Y. KHALIL
2062 CHARLES LANE
AKRON, OH 44333

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: 08/29/2024

Document No(s):

202424203198



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
30th day of August, A.D. 2024.

Ohio Secretary of State

Form 520 Prescribed by:



Toll Free: 877.767.3453
Central Ohio: 614.466.3910
OhioSoS.gov
business@OhioSoS.gov
File 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

CHECK ONLY ONE (1) Box

(1) ☐ 2024 ☒ Biennial Report
Indicate Year of Professional
Association (102-YRA)
(even-numbered years)

List Profession

(2) ☐ ☒ Biennial Report
Indicate Year of Limited Liability
Partnership (103-YRL)
(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

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)

Print Name

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

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.