



DATE	DOCUMENT ID	DESCRIPTION	FILING	EXPED	CERT	COPY
08/07/2026	202621803510	BIENNIAL REPORT OF PROFESSIONAL ASSOCIATION (26A)	25.00	0.00	0.00	0.00

Receipt

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

HARTVILLE INTERNAL MEDICINE INC.
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: 08/06/2026

Document No(s):

202621803510



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
7th day of August, A.D. 2026.

Ohio Secretary of State

Form 520 Prescribed by:



INSTRUCTIONS

- Include the filing fee.
- Make check or money order payable to Ohio Secretary of State.
- Print on single-sided 8 1/2 x 11 paper.
- Double sided paper will be rejected.
- Information must be typed.
- Illegible forms will be rejected

MAIL TO

Regular Service:
P.O. Box 788
Columbus, OH 43216
OR
Expedite Service:
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

RECEIVED

AUG 06 2026

CHECK ONLY ONE (1) Box

(1) ☐ 2026 ☐ Biennial Report
of Professional
Indicate Year Association (102-YRA)
(even-numbered years)

List Profession

(2) ☐ ☐ Biennial Report
of Limited Liability
Indicate Year 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 Statutory Agent

Agent Address (Post office boxes and CMRA's are **NOT** allowed. See instructions for details.)

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.