



DATE:	DOCUMENT ID	DESCRIPTION	FILING	EXPED	PENALTY	CERT	COPY
11/19/2009	200932300226	LIMITED PARTNERSHIP (CLP)	125.00	.00	.00	.00	.00

Receipt

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

COHEN, TODD, KITE & STANFORD, LLC
 ATTN: KELLY BURCHETT
 250 E. 5TH ST., SUITE 1200
 CINCINNATI, OH 45202

STATE OF OHIO
CERTIFICATE

Ohio Secretary of State, Jennifer Brunner

1896683

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

WOMEN'S MED PLUS CENTER LIMITED PARTNERSHIP

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

Document(s)

LIMITED PARTNERSHIP

Document No(s):

200932300226



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 18th day of November,
 A.D. 2009.

Ohio Secretary of State



Form 531A Prescribed by the:
Ohio Secretary of State

Central Ohio: (614) 466-3910
Toll Free: (877) SOS-FILE (787-3453)

www.sos.state.oh.us
Busserv@sos.state.oh.us

Expedite this form: (select one)
Mail form to one of the following:
 Expedite PO Box 1390
Columbus, OH 43216
*** Requires an additional fee of \$108 ***
 Non Expedite PO Box 670
Columbus, OH 43216

CERTIFICATE OF DOMESTIC LIMITED PARTNERSHIP
Filing Fee: \$125
(141-CLP)

RECEIVED
NOV 18 2009

SECRETARY OF STATE

Name of the Partnership Women's Med Plus Center Limited Partnership
Name must include one of the following words or abbreviations:
"Limited Partnership," "L.P.," "Limited," or "Ltd."

Address of the Partnership's Principal Place of Business PO Box 43100
Mailing Address
Cincinnati OH 45243
City State Zip Code

Effective Date (Optional) _____ (The status of the partnership as a limited partnership begins upon the filing of the certificate or on a later date specified that is not more than ninety days after filing)

Name and Address of Each General Partner

Name	Business or Residential Address
<u>Forte Management Corporation</u>	<u>PO Box 43100, Cincinnati, Ohio 45243</u>
_____	_____
_____	_____

ORIGINAL APPOINTMENT OF AGENT

The undersigned authorized representative(s) of
Women's Med Plus Center Limited Partnership

Name of Limited Partnership

hereby appoints the following to be Statutory Agent upon whom any process, notice or demand required or permitted by statute to be served upon the limited partnership may be served. The name and address of the agent is

Valerie Haskell

Agent Name

PO Box 43100

Mailing Address

Cincinnati

Ohio

State

45243

Zip Code

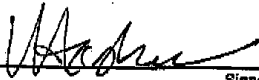
City

ACCEPTANCE OF APPOINTMENT

The undersigned, named herein as the statutory agent for
Women's Med Plus Center Limited Partnership

Name of Limited Partnership

hereby acknowledges and accepts the appointment of agent for said limited partnership



Signature of Statutory Agent

If the agent is an individual using a P.O. Box, the agent must check this box to confirm that he or she is an Ohio resident.

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
Must be authenticated
(signed) by all
general partners

FORTE MANAGEMENT CORPORATION

By: W. Martin Haskell 11/18/09
Signature Date

W. Martin Haskell, Treasurer

Print Name

Signature

Date

Print Name

Signature

Date

Print Name

Signature

Date

Print Name