DATE	DOCUMENT ID	DESCRIPTION	FILING	EXPED	PENALTY	CERT	COPY
07/28/2014	201420601712	BIENNIAL REPORT OF PROFESSIONAL CORP (14A)	25.00	0.00	0.00	0.00	0.00

Receipt

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

THE FOUNDER'S WOMENS HEALTH CENTER
1243 E. BROAD STREET
COLUMBUS, OH 43205

STATE OF OHIO
CERTIFICATE

Ohio Secretary of State, Jon Husted

754373

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

DOWNTOWN GYNECOLOGISTS, INC.

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

Document(s)	Document No(s):
BIENNIAL REPORT OF PROFESSIONAL CORP	**201420601712**

Effective Date: 07/17/2014

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 28th day of July, A.D. 2014.

Jon Husted

Ohio Secretary of State

Form 520 Prescribed by the:
Ohio Secretary of State

Central Ohio: (614) 466-3910
Toll Free: (877) SOS-FILE (767-3453)

www.OhioSecretaryofState.gov
Busserv@OhioSecretaryofState.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

Biennial Report

(Domestic,Professional Association,Domestic or Foreign LLP)

Filing Fee: $25

Check Only One (1) Box

(1) [X] 2014 Indicate Year — Biennial Report of Professional Corporation (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: DOWNTOWN GYNECOLOGISTS, INC.

Charter or Registration Number: 754373

2014 JUL 17 PM 2:12

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

Shareholders of Professional Corporation

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
Harley M. Blank, MD	1243 E. Broad St. Columbus, OH 43205
Karl I. Schaeffer, MD	1243 E. Broad St. Columbus, OH 43205
Robert Chosy, MD	1243 E. Broad St. Columbus, OH 43205

Complete the 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 | OHIO | 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 | OHIO | 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.

Harley M. Blank, MD
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.