



DATE:	DOCUMENT ID	DESCRIPTION	FILING	EXPED	PENALTY	CERT	COPY
10/07/2009	200928000788	ANNUAL REPORT OF PROFESSIONAL CORP (01A)	25.00	.00	.00	.00	.00

Receipt

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

NSI
 ATTN: TENA LUMPKINS
 145 BAKER STREET
 MARION, OH 43302

STATE OF OHIO
CERTIFICATE

Ohio Secretary of State, Jennifer Brunner

566276

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

ORTHOPEDIC RECONSTRUCTIVE SURGERY, INC.

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

Document(s)

ANNUAL REPORT OF PROFESSIONAL CORP

Document No(s):

200928000788



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 22nd day of September,
 A.D. 2009.

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.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 \$100 ***

Non Expedite PO Box 788
Columbus, OH 43216

BIENNIAL REPORT
Filing Fee: \$25

(CHECK ONLY ONE (1) BOX)

(1) 2001 (indicate year) Biennial Report
of Professional Corporation (102-YRA)
(even-numbered years)

List Profession orthopedic surgery

(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 Orthopedic Reconstructive Surgery, Inc.

Charter or Registration Number 566276

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

Shareholders of Professional Corporation
Authenticating this form constitutes a certification that all of 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
<u>Dr. Kenneth Pohl</u>	<u>5692 Far Hills Ave #4</u>
_____	<u>Dayton OH 45429</u>
_____	_____
_____	_____
_____	_____
_____	_____

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

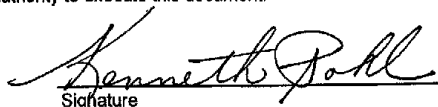
Zip Code

If the agent is an individual using a P.O. Box, check this box to confirm that the agent 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 an authorized
representative
(See Instructions)



Signature

9-29-09
Date

Dr. Kenneth Pohl

Print Name