

**2008 FOR PROFIT CORPORATION
ANNUAL REPORT**

FILED
Feb 26, 2008 08:00 AM
Secretary of State

DOCUMENT # S23356

1. Entity Name
ORAL AND FACIAL SURGERY CENTER, P.A.



Principal Place of Business
200 WEST OAK STREET
KISSIMMEE, FL 34741

Mailing Address
200 WEST OAK STREET
KISSIMMEE, FL 34741



01232008 No Chg-P CR2E034 (11/05)

DO NOT WRITE IN THIS SPACE

4. FEI Number
59-3001552

Applied For
Not Applicable

5. Certificate of Status Desired ☐

\$8.75 Additional
Fee Required

6. Name and Address of Current Registered Agent

BEDFORD, WINSTON G
200 WEST OAK STREET
KISSIMMEE, FL 34741

**DO NOT WRITE
IN THIS SPACE**

8. The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. I am familiar with, and accept the obligations of registered agent.

SIGNATURE

Signature, typed or printed name of registered agent and title if applicable

(NOTE: Registered Agent signature required when reinstating)

DATE

FILE NOW!!! FEE IS \$150.00
After May 1, 2008 Fee will be \$550.00

9. Election Campaign Financing
Trust Fund Contribution. ☐

\$5.00 May Be
Added to Fees

10. OFFICERS AND DIRECTORS

TITLE PT
NAME BEDFORD, WINSTON G DMD, MD
STREET ADDRESS 200 WEST OAK STREET
CITY- ST- ZIP KISSIMMEE, FL 34741

TITLE D
NAME LEVINE, HAL J DMD, MD
STREET ADDRESS 200 WEST OAK STREET
CITY- ST- ZIP KISSIMMEE, FL 34741

TITLE D
NAME YDRACH, ARTURO A DMD
STREET ADDRESS 200 WEST OAK STREET
CITY- ST- ZIP KISSIMMEE, FL 34741

TITLE
NAME
STREET ADDRESS
CITY- ST- ZIP

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CITY- ST- ZIP

U00000840395
03/06/08-80046-023 158.75

**DO NOT WRITE
IN THIS SPACE**

12. I hereby certify that the information supplied with this filing does not qualify for the exemptions contained in Chapter 119, Florida Statutes. I further certify that the information indicated on this report or supplemental report is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am an officer or director of the corporation or the receiver or trustee empowered to execute this report as required by Chapter 607, Florida Statutes; and that my name appears in Block 10 or Block 11 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE:

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Winston G. Bedford DMD, MD

1/30/08

Date

407-352-6301

Daytime Phone #