

**2021 FLORIDA PROFIT CORPORATION ANNUAL REPORT**

DOCUMENT# P20000072691

**Entity Name:** BLUE WATER ORAL SURGERY CENTER, P.A.

**Current Principal Place of Business:**

4400 EAST HWY 20  
STE 111  
NICEVILLE, FL 32578

**Current Mailing Address:**

4400 EAST HWY 20  
STE 111  
NICEVILLE, FL 32578 US

**FEI Number:** 85-3378726

**Certificate of Status Desired:** No

**Name and Address of Current Registered Agent:**

HARRELSON, BRADLEY D D.M.D.  
1672 SAINT LAWRENCE DRIVE  
NICEVILLE, FL 32578 US

*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.*

**SIGNATURE:**

\_\_\_\_\_  
Electronic Signature of Registered Agent

\_\_\_\_\_  
Date

**Officer/Director Detail :**

Title P  
Name HARRELSON, BRADLEY D D.M.D.  
Address 4400 EAST HWY 20  
STE 111  
City-State-Zip: NICEVILLE FL 32578

Title T  
Name HARRELSON, BRADLEY D D.M.D.  
Address 4400 EAST HWY 20  
STE 111  
City-State-Zip: NICEVILLE FL 32578

Title S  
Name HARRELSON, BRADLEY D D.M.D.  
Address 4400 EAST HWY 20  
STE 111  
City-State-Zip: NICEVILLE FL 32578

*I hereby certify that the information indicated on this report or supplemental report is true and accurate and that my electronic 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 above, or on an attachment with all other like empowered.*

**SIGNATURE:** BRADLEY HARRELSON

**PRESIDENT**

**04/04/2021**

\_\_\_\_\_  
Electronic Signature of Signing Officer/Director Detail

\_\_\_\_\_  
Date