

FILE NOW: FILING FEE AFTER MAY 1 IS \$550.00

PROFIT  
CORPORATION  
ANNUAL REPORT  
1997



FLORIDA DEPARTMENT OF STATE  
Sandra B. Mortham  
Secretary of State  
DIVISION OF CORPORATIONS

DOCUMENT # P96000078788 (2)

1. Corporation Name  
PRINCE CLEANERS INC.

Principal Place of Business

25 SE 2ND AVE., #207  
MIAMI FL 33131

Mailing Address

25 SE 2ND AVE., #207  
MIAMI FL 33131-1508

97 JUL 15 AM 10:57

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA



3. Date Incorporated or Qualified  
09/19/1996

3a. Date of Last Report

4. FEI Number

65-0710445

Applied For  
Not Applicable

5. Certificate of Status Desired

☐ \$8.75 Additional  
Fee Required

6. Election Campaign Financing  
Trust Fund Contribution

☐ \$5.00 May Be  
Added to Fees

8. This corporation has liability for intangible tax under s. 199.032,  
Florida Statutes

☐ Yes ☒ No

2. Principal Place of Business

21 Suite, Apt. #, etc.

22 City & State

23 Zip Country

24 25

2a. Mailing Address

26 Suite, Apt. #, etc.

27 City & State

28 Zip Country

29 30

9. Name and Address of Current Registered Agent

ODHWANI, NAZMIN  
25 SE 2ND AVE., #207  
MIAMI FL 33131

10. Name and Address of New Registered Agent

81 Name

82 Street Address (P.O. Box Number is Not Acceptable)

83

84 City

FL 85 Zip Code

11. Pursuant to the provisions of Sections 607.0502 and 607.1508, Florida Statutes, the above-named corporation submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with, and accept the obligations of, Section 607.0505, Florida Statutes.

SIGNATURE

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

(NOTE: Registered Agent signature required when reinstating)

DATE

12. OFFICERS AND DIRECTORS

TITLE ☐ DELETE

NAME  
D ODHWANI, NAZMIN  
STREET ADDRESS  
25 SE 2ND AVE., #207  
CITY-ST-ZIP  
MIAMI FL 33131

TITLE ☐ DELETE

NAME  
STREET ADDRESS  
CITY-ST-ZIP

TITLE ☐ DELETE

NAME  
STREET ADDRESS  
CITY-ST-ZIP

TITLE ☐ DELETE

NAME  
STREET ADDRESS  
CITY-ST-ZIP

TITLE ☐ DELETE

NAME  
STREET ADDRESS  
CITY-ST-ZIP

TITLE ☐ DELETE

NAME  
STREET ADDRESS  
CITY-ST-ZIP

13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12

☐ Change ☐ Addition

11 TITLE

12 NAME

13 STREET ADDRESS

14 CITY-ST-ZIP

21 TITLE

22 NAME

23 STREET ADDRESS

24 CITY-ST-ZIP

31 TITLE

32 NAME

33 STREET ADDRESS

34 CITY-ST-ZIP

41 TITLE

42 NAME

43 STREET ADDRESS

44 CITY-ST-ZIP

51 TITLE

52 NAME

53 STREET ADDRESS

54 CITY-ST-ZIP

61 TITLE

62 NAME

63 STREET ADDRESS

64 CITY-ST-ZIP

☐ Change ☐ Addition

☐ Change ☐ Addition

☐ Change ☐ Addition

☐ Change ☐ Addition

14. I do hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(i), Florida Statutes. I further certify that the information indicated on this annual report or supplemental annual 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 12 or Block 13 if changed, or on an attachment with an address.

NAZMIN ODHWANI

331 371 362 0

CR2E034 (9/96)

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July 10, 1997

Florida Department of State  
Secretary of State  
Division of Corporations

**Reference: Galaxy International Inc.  
Luxury Watch Co., Inc.  
Prince Cleaners Inc.**

Please find enclosed the 1997 Annual Report with the checks for the above referenced client. These Annual Reports are filed late because of my health related problem. I would appreciate if you would waive the late charges. Also enclosed, please find a statement from my doctor regarding my medical condition.

If you need additional information, please do not hesitate to contact me.

Thank you,

Nazmin Odhwani

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SAWGRASS  
FAMILY MEDICAL CENTER  
7604 N.W. 186th ST.  
MIAMI FL. 33015

MULTIPURPOSE FORM FOR PROOF OF SERVICES

Instructions: Form must be signed by the Primary Care Physician.  
Please Fill in the appropriate lines. Purpose must  
be stated. Copy shall be made for client's Chart.

Client: Nazmin Odhmani I.D. No.: 2083

☒ Client was seen at SAWGRASS FAMILY MEDICAL CENTER on the date(s) of:  
5/20/97, 5/29/97, 6/17/97, 6/27/97

and is currently being followed for the following conditions/  
diagnoses:  
Intermittent Acute Chronic Arthritis

\_\_\_\_\_ This condition is expected to be of a temporary nature for the  
following time period and may be reevaluated at that time \_\_\_\_\_

\_\_\_\_\_ He/She MAY NOT return to work/school until \_\_\_\_\_

\_\_\_\_\_ He/She was advised to return to the clinic on: 7/27/97

\_\_\_\_\_ This form was completed for the stated purpose of:

\_\_\_\_\_ ☐ Food Stamp Eligibility

☒ Permission to return to work

\_\_\_\_\_ Permission to return to school

\_\_\_\_\_ Other: \_\_\_\_\_

7/7/97  
Date

N. Odhmani M.D.  
Physician's Signature

I understand that the above Information is for my medical/social welfare  
and I give my consent to the release of this information. I will be  
responsible for the re-release of this information.

N. Odhmani  
Patient's Signature

Note: THIS LETTER IS NOT A DETERMINATION OF PERMANENT DISABILITY  
(A copy of this Multipurpose Form becomes a part of the Patient's  
Health Care Medical Record).