

<b>STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY</b>	<b>DOMESTIC RELATIONS JUDGMENT INFORMATION, PAGE 1</b> <input type="checkbox"/> TEMPORARY <input type="checkbox"/> FINAL	<b>CASE NO.</b>
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**USE NOTE:** Complete this form and file it with the friend of the court (**do not file this form with the office of the clerk of the court**) when the first temporary custody, parenting-time, or support order is entered and when submitting any final proposed judgment awarding custody, parenting time, or support. Mail a copy to each party and file proof of mailing with the court (may use form MC 302, Proof of Mailing).

(Check this box when information is being modified.) Except as otherwise indicated below, all information previously provided is unchanged.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature

**Plaintiff Information**

**Defendant Information**

Name		Name	
Address		Address	
Social security number	Telephone number	Social security number	Telephone number
Employer name, address, telephone number, and FEIN (if known)		Employer name, address, telephone number, and FEIN (if known)	
Driver's license number and state		Driver's license number and state	
Occupational license number(s), type(s), issuing state(s), and date(s)		Occupational license number(s), type(s), issuing state(s), and date(s)	

**CUSTODY PROVISIONS**

sole, plaintiff = P    sole, defendant = D    joint = J    other = O \_\_\_\_\_  
(must identify)

Child's name	Social security number	Date of birth	Physical custody P, D, J, O	Child's primary residence address	Legal custody P, D, J, O

**SUPPORT PROVISIONS**

Support provisions are stated in the Uniform Support Order.  
Medical Support provisions are stated on page 2 of this form.

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**MEDICAL SUPPORT PROVISIONS:** List the name of each insurance provider for the plaintiff and the defendant. Then enter the name of each child in this case who is covered by that provider and the type of coverage provided.

**Plaintiff's Insurance Coverage**

Name and address of provider	Policy no.	Cert. no.	Child(ren)'s name(s)	Medical	Dental	Optical	Other

**Defendant's Insurance Coverage**

Name and address of provider	Policy no.	Cert. no.	Child(ren)'s name(s)	Medical	Dental	Optical	Other