STATE OF MICHIGAN 30TH JUDICIAL CIRCUIT INGHAM COUNTY	**OBJECTION TO THE NOTICE OF UNINSURED MEDICAL EXPENSES FRIEND OF THE COURT**	CASE NO: JUDGE:

Plaintiff's name, address and telephone no. Attorney:	VS.	Defendant's name, address and telephone no. Attorney:

TWO COPIES OF THIS OBJECTION MUST BE FILED WITH THE FRIEND OF THE COURT, P.O. BOX 40097, 303 W. Kalamazoo St., LANSING MI 48901 IF YOU ARE MAILING YOUR OBJECTION TO THE FRIEND OF THE COURT OFFICE, PLEASE USE THE P.O. BOX ONLY. **

1. The Office of Friend of the Court has requested reimbursement for the uninsured health care expenses in the amount of $_____.

2. I, _____, object to the payment of health care expenses for the following reasons: ***(You must be specific in your objections.)***

(Use separate sheet if enough room is not provided)

3. I request a hearing before the Office of the Friend of the Court regarding this matter and my objection.

Date: _____

_____
Signature of party, Plaintiff /Defendant

CERTIFICATE OF MAILING

I certify that on this date I mailed a copy of this Objection to other party by ordinary mail addressed to his/her last known address.

Date: _____

_____
Signature

4/12/12