
Full name of Party Filing this Document

Mailing Address (Street or Post Office Box)

City, State and Zip Code

Telephone Number

IN THE DISTRICT COURT OF THE _____ JUDICIAL DISTRICT OF THE
STATE OF IDAHO, IN AND FOR THE COUNTY OF _____

_____,
Father

_____,
Mother

State Of Idaho, Department Of Health And Welfare

_____,
Plaintiff or Co-Petitioner,
vs.

_____,
Defendant or Co-Petitioner.

MOTION TO CONSOLIDATE

Case No. _____

Case No. _____

There is more than one case involving the same parties or claims. The court should consolidate these cases. Rule 42(a), IRCP. I ask for oral argument. Rule 7(b)(3) IRCP.

DATED: _____

(Signature of Parent)

DATED: _____

(Signature of Parent)

CERTIFICATE OF SERVICE

I certify I served a copy to: (Fill in the mailing address of the attorney for the Department of Health & Welfare and the other parent's name and mailing address if they did not sign above)

(Name)

(Street or Post Office Address)

(City, State, and Zip Code)

By Mail

By fax to (number) _____

By personal delivery

(Name)

(Street or Post Office Address)

(City, State, and Zip Code)

By Mail

By fax to (number) _____

By personal delivery

Date: _____

Signature

Typed/printed Name of Party Signing