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New Jersey Judiciary

Confidential Litigant Information Sheet (*R.* 5:4-2(g))

To assure accuracy of court records - To be filled out by Plaintiff, or Defendant, or Attorney
Collection of the following information is pursuant to *N.J.S.A.* 2A:17-56.60 and *R.* 5:7-4.

Confidentiality of this information must be maintained

Please complete the entire form, leaving no blank spaces. If something does not apply to you, enter "N/A". This form is confidential and will not be shared with the other party.

Docket Number:	CS Number:	Do you have an active Domestic Violence Order with the other party in this case? ☐ Yes ☐ No

Plaintiff	**Defendant**
Name (last, first, middle initial)	**Name (last, first, middle initial)**
Social Security Number / Date of Birth	Social Security Number / Date of Birth
Address: Street City / State / Zip	Address: Street City / State / Zip
Plaintiff Telephone Number / Employer Telephone Number	Defendant Telephone Number / Employer Telephone Number
Plaintiff Email Address	Defendant Email Address
Employer Name (or other income source)	Employer Name (or other income source)
Employer Address: Street City / State / Zip	Employer Address: Street City / State / Zip
Professional, Occupational, Recreational Licenses (include types and license numbers)	Professional, Occupational, Recreational Licenses (include types and license numbers)
Driver's License Number / State of Issuance	Driver's License Number / State of Issuance
Sex / Race/Ethnicity / Height / Weight / Eyes / Hair	Sex / Race/Ethnicity / Height / Weight / Eyes / Hair
Auto: License Plate / State / Make / Model / Year	Auto: License Plate / State / Make / Model / Year
Attorney Name	Attorney Name
Attorney Address: Street City / State / Zip	Attorney Address: Street City / State / Zip

Children Information

Name (last, first, middle initial)	Date of Birth	Race	Sex	Social Security Number
1.				
2.				
3.				
4.				

Health Coverage for Children - available through parent filling out this form (☐ Plaintiff / ☐ Defendant)

Health Care Provider: _____ Policy Number: _____ Group Number: _____

Health Care Provider: _____ Policy Number: _____ Group Number: _____

Health Care Provider: _____ Policy Number: _____ Group Number: _____

I certify that the foregoing statements made by me are true to the best of my knowledge. I am aware that if any of the foregoing statements made by me are wilfully false, I am subject to punishment.

Date _____ Signature _____