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						Address: Street					
City			State	Zip		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						Employer Address: Street					
City			State	Zip		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						Attorney Address: Street					
City			State	Zip		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

Confidential