



**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? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
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<b>Plaintiff</b>			<b>Defendant</b>		
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<b>Name (last, first, middle initial)</b>			<b>Name (last, first, middle initial)</b>		
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Social Security Number	Date of Birth	Place of Birth	Social Security Number	Date of Birth	Place of Birth
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Address: Street			Address: Street		
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City	State	Zip	City	State	Zip
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Plaintiff Telephone Number	Employer Telephone Number	Defendant Telephone Number	Employer Telephone Number
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Employer Name (or other income source)	Employer Name (or other income source)
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Employer Address: Street			Employer Address: Street		
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City	State	Zip	City	State	Zip
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Professional, Occupational, Recreational Licenses (include types and license numbers)	Professional, Occupational, Recreational Licenses (include types and license numbers)
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Driver's License Number	State of Issuance	Driver's License Number	State of Issuance
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Sex Male	Race/Ethnicity	Height	Weight	Eyes	Hair	Sex Female	Race/Ethnicity	Height	Weight	Eyes	Hair
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Auto: License Plate	State	Make	Model	Year	Auto: License Plate	State	Make	Model	Year
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Attorney Name	Attorney Name
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Attorney Address: Street 1288 Rt. 73 South, Suite 301	Attorney Address: Street
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City Mt. Laurel	State NJ	Zip 08054	City	State	Zip
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**Children Information**

Name (last, first, middle initial)	Date of Birth	Race	Sex	Social Security Number	Place of Birth

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

<i>Health Care Provider</i>	<i>Policy #</i>	<i>Group #</i>
<i>Health Care Provider</i>	<i>Policy #</i>	<i>Group #</i>
<i>Health Care Provider</i>	<i>Policy #</i>	<i>Group #</i>

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
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Revised: 10/2012.