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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 / Place of Birth	Social Security Number / Date of Birth / Place of Birth
Address: Street	Address: Street
City / State: NJ / Zip	City / State: NJ / Zip
Plaintiff Telephone Number / Employer Telephone Number	Defendant Telephone Number / Employer Telephone Number
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): n/a	Professional, Occupational, Recreational Licenses (include types and license numbers): n/a
Driver's License Number / State of Issuance: New Jersey	Driver's License Number / State of Issuance: New Jersey
Sex / Race/Ethnicity / Height / Weight / Eyes / Hair	Sex / Race/Ethnicity / Height / Weight / Eyes / Hair
Auto: License Plate / State: NJ / Make / Model / Year	Auto: License Plate / State: NJ / Make / Model / Year
Attorney Name: Robert A. Gleaner, Esquire	Attorney Name: None
Attorney Address: Street: 415 S. White Horse Pike	Attorney Address: Street
City: Audubon / State: NJ / Zip: 08106	City / State / Zip

Children Information

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