



**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"/> Yes <input type="checkbox"/> No
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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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Plaintiff Email Address	Defendant Email Address
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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 54 Old Hwy 22, Suite 302	Attorney Address: Street
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City Clinton	State New Jersey	Zip 08809	City	State	Zip
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**Children Information**

<b>Name (last, first, middle initial)</b>	<b>Date of Birth</b>	<b>Race</b>	<b>Sex</b>	<b>Social Security Number</b>
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Health Coverage for Children - available through parent filling out this form ( Plaintiff /  Defendant)

Health Care Provider	Policy #	Group #
Health Care Provider	Policy #	Group #
Health Care Provider	Policy #	Group #

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