RESTITUTION INFORMATION

IF YOU ARE REQUESTING RESTITUTION, IT IS **REQUIRED** YOU COMPLETE THIS FORM AND RETURNED WITHIN 20 DAYS.

Mail to: DISTRICT ATTORNEY'S OFFICE
VICTIM WITNESS SERVICES
1516 CHURCH STREET
STEVENS POINT WI 54481

DEFENDANT: DA CASE NO.:

VICTIM: HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

Are you requesting restitution? **Yes** ☐ **No** ☐

Please list medical providers, and itemize property damaged/property loss **Amount :**

For medical please attach copies of bills or receipts from medical providers, clinic, hospital, doctor/ counselors. Statement of Benefits from your insurance company.
For property please attach estimates of loss or repair of damage. You must show proof of your request.

_____ _____

_____ _____

_____ _____

Did you miss work because of this injury? **YES** ☐ **NO** ☐
*If yes, please provide a letter from your employer stating dates missed, number of hours missed, hourly wage and total lost wages.

PLEASE COMPLETE THIS SECTION IF LOSSES WERE COVERED BY INSURANCE:

Insurance Company: _____ Amount of your Deductible: _____

Address: _____ Amount Paid by Insurance: _____

_____ Insured Name: _____

Claim/Policy No.: _____ Total Loss: _____

Date of Loss: _____

Agent' Name and Address: _____

_____

_____

VICTIM SIGNATURE: _____ **DATE:** _____

To the best of my knowledge, the above information is true and accurate.