

# VICTIM RESTITUTION SHEET

ATTACH DOCUMENT (RECEIPTS)

You Must Fill Out and Return (Even If No Restitution is Due)

Defendant Name _____	For Official Use Only _____
Docket No. Docket #:	ADA Reviewed: _____ Copy to Defense: _____ Yes _____ No

1. MEDICAL EXPENSES FOR INJURY

Hospital \_\_\_\_\_ Amount \_\_\_\_\_

Doctor \_\_\_\_\_ Amount \_\_\_\_\_

Pharmacy \_\_\_\_\_ Amount \_\_\_\_\_

Ambulance \_\_\_\_\_ Amount \_\_\_\_\_

Other \_\_\_\_\_ Amount \_\_\_\_\_

2. PROPERTY LOST/STOLEN AND NOT RECOVERED

Item \_\_\_\_\_ Amount \_\_\_\_\_

Item \_\_\_\_\_ Amount \_\_\_\_\_

3. PROPERTY DAMAGE TO BE REPLACED

Item \_\_\_\_\_ Amount \_\_\_\_\_

Item \_\_\_\_\_ Amount \_\_\_\_\_

4. INSURANCE COMPANY

Claim Made \_\_\_\_\_ Benefit Received \_\_\_\_\_

TOTAL AMOUNT OF LOSS, DAMAGE OR EXPENSES: \_\_\_\_\_

Comments for Judge regarding the defendants sentencing: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DATE \_\_\_\_\_ Victim/Complainant \_\_\_\_\_

Printed Name \_\_\_\_\_