PLEASE FILL OUT THIS ENTIRE PACKAGE AND RETURN TO:

District Attorney's Office
Attn: Victim / Witness Department
300 Iberia Street, Courthouse Building Suite 200
New Iberia, LA 70560-4583

Please provide the following information:

VICTIM'S NAME:_____DOB: _____

PARENT(S) / GUARDIAN OF CHILD VICTIM:_____

REPRESENTATIVE OF DECEASED VICTIM:_____

CURRENT MAILING ADDRESS: _____

_____

CURRENT PHONE NO: (H)_____ (C)_____

EMPLOYER: _____

EMPLOYER PHONE NUMBER: _____

****Please provide an additional contact person:**

CONTACT PERSON: _____

CONTACT PHONE NUMBER: _____

NOTE: It is important that you notify this office of any changes to your address or phone number.

VICTIM QUESTIONNAIRE

Defendant's Name:	For Office Use Only
Docket #:	ADA Reviewed:
Charge(s):	Copy to Defense ☐Yes ☐No

(If you need more space, please write on back of this sheet.)

SPECIFIC QUESTIONS

1. Do you believe incarceration (jail time) is required in this case and if so, for how long?

2. Do you believe that mental health or substance abuse treatment is necessary for the defendant?

3. Would you agree to a sentence of probation instead of jail time?

4. If the defendant is placed on probation, are there any special conditions of probation you would like to see imposed?

5. Do you wish to be present when the defendant is sentenced and speak to the judge?

6. List any physical injuries suffered as a result of the above crime:

7. Describe any change in personal welfare or family relationships as a result of this crime.

8. List any request for psychological or counseling services initiated as a result of the crime.

9. List any other relevant information in regard to the above crime. Please feel free to discuss your feeling about what has happened and how it has affected your general well being in regard to the above crime. (If extra space is needed, please feel free to attach additional sheets.)

Signature of Victim

Date

Printed Name:

VICTIM RESTITUTION SHEET
ATTACH DOCUMENTATION (RECEIPTS)

YOU MUST FILL OUT AND RETURN (EVEN IF NO RESTITUTION IS DUE)

Defendant Name:	For Office Use Only:
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 $_____
Item_____ Amount $_____
Item_____ Amount $_____

3. PROPERTY DAMAGE TO BE REPLACED

Item_____ Amount $_____
Item_____ Amount $_____
Item_____ Amount $_____

4. INSURANCE COMPANY

Claim Made_____ Benefit Received $_____

TOTAL AMOUNT OF LOSS, DAMAGE OR EXPENSES $ _____

Comments for Judge regarding the defendant's sentencing:_____
_____
_____
_____

Date:_____ Victim / Complaint_____
Printed Name _____