RESTITUTION INFORMATION

This form must be returned by:

TO: VICTIM WITNESS SERVICES
P O BOX 8095
WISCONSIN RAPIDS WI 54495-8095

DEFENDANT:

DISTRICT ATTORNEY CASE NO:

DA Case No.:

COURT CASE NO.:

VICTIM:

IF YOU DO NOT WANT TO APPLY FOR RESTITUTION,
PLEASE CHECK THIS BOX AND RETURN THIS FORM. ☐

Description of Injury/Damage
(Please attach copies of bills or receipts if you have them.)
Please itemize your losses

Amount :

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

PLEASE COMPLETE THIS SECTION IF LOSSES WERE COVERED BY INSURANCE:

Insurance Company: _____

Address: _____

_____

Claim/Policy No.: _____

Amount of your Deductible: _____

Amount Paid by Insurance Co.: _____

Total Loss: _____
(Including insurance deductible)

Agent's Name: _____

VICTIM SIGNATURE: _____ **DATE:** _____

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