RESTITUTION FORM

Case number _____ Case name_____
Victim's Name _____
Address _____
City/State /Zip _____
Home phone _____ Work phone _____
E-mail _____

If any of the above contact information changes, please contact the City Prosecutors at (208) 612-8169.

Please fill out all of the sections below that apply to the case number/name listed above. In order for you to be able to receive restitution for the losses you have suffered, it is important that you try to be a thorough as possible.

MEDICAL EXPENSES INCURRED AS A RESULT OF INJURIES SUSTAINED FROM A CRIMINAL ACT
(Use back side or separate sheet if necessary)

Service Provider	Date of Service	Amount of Bill	Amount Paid by Insurance	Did You Apply for Victims Compensation
1.				
2.				
3.				
4.				
5.				

COUNSELING EXPENSES INCURRED AS A RESULT OF A CRIMINAL ACT

Service Provider	Date of Service	Amount of Bill	Amount Paid by Insurance	Did you Apply for Victims Compensation
1				
2.				
3.				

Insurance Co/Agent	Address	Phone Number
What has your Insurance Co. paid on your behalf to date? (Amount and to whom)	What is the amount of the deductible you have paid?	
What wages, if any, were lost directly due to physical injuries sustained as a result of this criminal act and where you could not work due to those injuries?	How is the wage loss calculated?	Work Supervisor & Phone #
What is the total loss that you have suffered? Include both losses to you and your insurance company.		$

I, _____, hereby certify that all of the information on this form is true and correct and I recognize that I may have to testify in court under oath, and under penalties of perjury, concerning the information I have provided on this form.

Dated: _____, 20___.

_____
Signature of Victim/Agent for Victim

PLEASE SEND THIS FORM TO:

City Prosecutors
P.O. Box 50220
Idaho Falls, ID 83405-0220

Esta formulario esta disponible en Espanol en la pagina de internet de la Ciudad de Idaho Falls bajo "City Attorney"