

VICTIM RESTITUTION FORM

Victim Name: _____

Current Address: _____

Phone Number: _____

Cause Number: _____

Please be as specific as possible when listing amounts. Attach estimates, receipts, and/or wage verification. Without receipts we will be unable to file your restitution claim with the court.

Total Amount of Out-of-Pocket Expenses and Costs (including insurance deductible, medical bills, property loss or damage) not including lost wages:

\$ _____

Amount paid by your insurance company:

\$ _____

Amount paid by defendant's insurance company:

\$ _____

Did you have lost wages? Yes No

If yes, how much?

\$ _____

If you are seeking lost wages from missed work because of this incident, you will need to provide a letter from your employer on company letterhead that states the times and dates you were absent from work.

Has the defendant reimbursed you any money? Yes No

If yes, how much?

\$ _____

I swear or affirm under penalties of perjury that the foregoing information is true to the best of my knowledge and belief.

Signature: _____

Date: _____

Please complete and return within 10 days to:
Clinton County Prosecutor's Office
475 Courthouse Square
Frankfort, IN 46041