RESTITUTION FORM

RE:
CASE NO.:
OFFENSE:
DATE OF OFFENSE:
TRIAL DATE:

Return completed form to:
Office of the District Attorney
Attn: Victim/Witness Assistance
Bucks County Courthouse, 4th floor
Doylestown, Pa. 18901
FAX: (215) 340-8885

Victim name:
Address: Home Phone: _____

Business Phone: _____

List below the cost of property damage and/or medical expenses (supported by estimates or actual bills) and/or the fair value of unrecovered stolen property or deductible not covered by insurance. **These are the only expenses we can request for Restitution. (WE CANNOT REQUEST RESTITUTION FOR LOST WAGES).**

Description of Loss (you must attach actual bills, estimates or supporting documentation) **$ AMOUNT**

Total Loss: $ _____

Minus amount paid by Insurance Co.: $ _____

Total Restitution Request: $ _____

Is the above loss/damage covered by insurance? YES _____ NO _____

If **NO**, why? _____

Name/Address/Phone of your Insurance Agent:

_____
_____
_____
_____

Claim no.: _____

Restitution will **NOT** be requested for you or your insurance company unless this form is received by our office **BEFORE** the trial date. Please notify your insurance company that they **MUST** send us a request along with supporting documentation if they would like to request restitution.

_____

Victim Signature **Date**