

RESTITUTION INFORMATION

This form must be returned by:

TO: Victim Witness Services
District Attorney's Office
222 North Iowa Street
Dodgeville, WI 53533

DEFENDANT:

DISTRICT ATTORNEY:

CHARGES:

COURT CASE NO.:

VICTIM:

HOME PHONE:

ADDRESS:

WORK PHONE:

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

Description of Injury/Damage

Amount :

(Please attach copies of bills or receipts if you have them.)

PLEASE COMPLETE THIS SECTION IF LOSSES WERE COVERED BY INSURANCE:

Insurance Company: _____ Amount Deductible: _____

Address: _____ Amount Paid by Insurance Co.: _____

Claim/Policy No.: _____ Total Loss to Victim: _____
(Including insurance deductible) _____

Agent's Name and Address: _____

VICTIM SIGNATURE: _____ **DATE:** _____