

DOUGLAS COUNTY DISTRICT ATTORNEY'S OFFICE

8700 Hospital Drive, 2nd Floor Douglasville, GA 30134

Phone: (770) 920-7292/Fax: (770) 920-7123

CRIME VICTIM IMPACT STATEMENT

VICTIM'S NAME: _____

ADDRESS: _____

EMAIL ADDRESS: _____

PHONE (Home)_____ (Work) _____ (Cell) _____

NAME OF PERSON OTHER THAN VICTIM COMPLETING FORM: _____

RELATIONSHIP TO VICTIM: _____

DEFENDANT'S NAME: _____

DATE CRIME OCCURRED: _____

1. Briefly describe the crime committed against you or your family (Additional pages can be attached to answer this or any of the following questions.)

2. Were you physically injured because of this crime? _____ If yes, please describe the injury, how serious and how long the injury lasted or will last.

3. Did your injuries require medical attention? _____ If yes, please tell what treatment was received and how long the treatment was or will be needed.

4. If medical treatment was required, have you completed a restitution form and attached copies or receipts? Yes_____ No_____

OVER

5. Were you or your family emotionally injured because of this crime? ____ If yes, tell how this injury affected you or your family. (An emotional injury may include change of attitude or feelings, fear, change in lifestyle, emotional problems, etc.)

6. Have you or your family received or requested counseling or therapy because of this crime? ____ If yes, tell how long you or your family have received or will receive counseling or therapy.

7. If counseling was required, have you completed a restitution form and attached copies of bills or receipts? Yes ____ No ____

8. Did any property damage occur because of this crime? ____ If yes, please describe the damage.

9. If property damage occurred, have you completed a restitution form and attached copies of bills or receipts? Yes ____ No ____

10. Did this crime prevent you from working? Yes ____ No ____

11. Please share any additional views you would like to express.

This Victim Impact Statement is signed and affirmed as true under the penalties of perjury.

Signature: _____ Date: _____

**MAIL COMPLETED FORM TO: DOUGLAS COUNTY DISTRICT ATTORNEY'S OFFICE
VICTIM/WITNESS PROGRAM
8700 HOSPITAL DRIVE, 2ND FLOOR
DOUGLASVILLE, GA 30134**