

DOUGLAS COUNTY DISTRICT ATTORNEY'S OFFICE

8700 Hospital Drive, 2nd Floor Douglasville, GA 30134

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

RESTITUTION FORM

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: _____

MEDICAL EXPENSES (INCLUDE COUNSELING):

MEDICAL EXPENSES	AMOUNT PAID BY YOU	AMOUNT PAID BY INSURANCE
TOTAL: \$	TOTAL: \$	TOTAL: \$

PROPERTY DAMAGE OR LOSS:

TYPE OF PROPERTY	AMOUNT PAID BY YOU	AMOUNT PAID BY INSURANCE
TOTAL: \$	TOTAL: \$	TOTAL: \$

INSURANCE COMPANY INFORMATION (IF APPLICABLE)

NAME: _____

PHONE: _____

POLICY NO.: _____

OVER

FINANCIAL TRANSACTION CARD FRAUD:

BRAND: VISA, MASTERCARD, DISCOVER, ETC.	TYPE OF CARD (DEBIT CARD, CREDIT CARD)	TRANSACTION AMOUNT(S)
		TOTAL: \$

WERE YOU REIMBURSED BY THE BANK/INSTITUTION FOR THE FRAUDULENT CHARGES?

YES ___ NO ___

PLEASE PROVIDE THE NAME OF BANK/INSTITUTION THAT ISSUED ACCOUNT OR CARD:

NAME: _____

PHONE: _____

FORGERY:

CHECK NO.	AMOUNT	SERVICE FEE
	TOTAL: \$	TOTAL: \$

GRAND TOTAL	\$
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PLEASE ATTACH ANY AND ALL RECEIPTS OR DOCUMENTS RELATED TO THE ABOVE LOSS.

THIS STATEMENT IS SIGNED AND AFFIRMED AS TRUE AND 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**