VICTIM RESTITUTION REQUEST

Please return this completed form, along with documentation (receipts, medical bills, etc.) regarding any expenses incurred as a result of the crime(s) to:

Bossier Parish Office
26th Judicial District Attorney's Office
Attn: Victim Assistance Coordinator
P.O. Box 69
Benton, LA 71006
Email: rreeves@26thda.org

Webster Parish Office
26th Judicial District Attorney's Office
Attn: Victim Assistance Coordinator
P.O. Box 758
Minden, LA 71058
Email: eward@26thda.org

FAILURE TO RETURN THIS FORM MAY AFFECT RESTITUTION COLLECTION

Defendant's Name: _____

Victim's Name: _____

Victim's Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers: Cell: _____ Work: _____

1. **MEDICAL EXPENSES**:

Hospital: _____ Amount: _____ Receipt: Yes ☐ No ☐

Doctor: _____ Amount: _____ Receipt: Yes ☐ No ☐

Pharmacy: _____ Amount: _____ Receipt: Yes ☐ No ☐

Other: _____ Amount: _____ Receipt: Yes ☐ No ☐

2. PROPERTY LOST/STOLEN AND NOT RECOVERED:

Item: _____ Amount: _____ Receipt: Yes ☐ No ☐

Item: _____ Amount: _____ Receipt: Yes ☐ No ☐

Item: _____ Amount: _____ Receipt: Yes ☐ No ☐

3. PROPERTY DAMAGED TO BE REPLACED OR REPAIRED:

Item: _____ Amount: _____ Receipt: Yes ☐ No ☐

Item: _____ Amount: _____ Receipt: Yes ☐ No ☐

Item: _____ Amount: _____ Receipt: Yes ☐ No ☐

4. INSURANCE COMPANY:

Name of Insurer: _____ Benefit Received: _____

TOTAL AMOUNT OF LOSS, DAMAGES OR EXPENSES: _____

Comments for Assistant District Attorney regarding the Defendant's sentencing: _____

_____

_____

_____

Date: _____ Victim Signature: _____

PLEASE ATTACH AN ADDITIONAL SHEET IF YOU NEED MORE SPACE

FOR OFFICIAL OFFICE USE ONLY

Defendant's Name: _____ Date Received: _____

Docket Number: _____ ADA Reviewed: _____