



RESTITUTION CLAIM FORM

Be aware that the decision to assess restitution is up to the Judge at the time of sentencing. Please complete and return this form with copies of your bills and/or estimates to our office at your earliest convenience:

Victim = s Rights Unit
201 McMorran Boulevard, Room 3308
Port Huron, MI 48060

Victim Information (the fields in red are required):

Name: [redacted] Date: [redacted]
Address: [redacted]
City, State, Zip: [redacted]
Phone (you may provide multiple): [redacted]
Email: [redacted]
Name of Defendant(s)/Respondent(s): [redacted]

Please select the answer for the following:

- (1) This claim is for: medical bills property loss/damage
(2) Are you insured? Yes No
(3) If yes: Insurance Company Name [redacted]:
Address: [redacted]
Phone: [redacted]
Policy Holder's Name: [redacted]
Policy #: [redacted]
Amount of deductible: [redacted]

Itemization of Loss(es): Do not include any items that were recovered or reimbursed by your insurance company.

	Amount
1. INSURANCE DEDUCTIBLE, IF ANY	[redacted]
2. [redacted]	[redacted]
3. [redacted]	[redacted]
4. [redacted]	[redacted]
5. [redacted]	[redacted]
6. [redacted]	[redacted]
7. [redacted]	[redacted]
8. [redacted]	[redacted]
9. [redacted]	[redacted]
10. [redacted]	[redacted]
11. [redacted]	[redacted]
12. [redacted]	[redacted]
Total	[redacted]

Signature _____

Date _____

Our office will not disclose your information to the defendant or the defense attorney.

