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

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 _____:
Address: _____
Phone: _____
Policy Holder's Name: _____
Policy #: _____
Amount of deductible: _____

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

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

_____ _____
Signature Date

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