



## REQUEST FOR RESTITUTION

Commonwealth v. \_\_\_\_\_ Court Date: \_\_\_\_\_

### Victim's Information

Name:	_____	Phone #	_____
Address:	_____	Alt Phone #:	_____
City, State, Zip	_____	Email address:	_____

### ECONOMIC LOSS

#### Property Loss

List property lost as a result of this crime; e.g., property that has not and is not expected to be recovered (Attach any relevant receipts).

ITEM	MAKE (if applicable)	MODEL (if applicable)	VALUE
			Total \$

#### Property Damage

List property damaged as a result of this crime. (Attach any relevant receipts).

ITEM	MAKE (if applicable)	MODEL (if applicable)	VALUE
			Total \$

#### Total Medical/Hospital Costs

(Attach copies of bills) ..... Total \$ \_\_\_\_\_

**TOTAL LOSS** \$ \_\_\_\_\_

(Circle yes or no to answer the questions below)

Was the property recovered by law enforcement?                      YES                      NO

If recovered, has the property been returned to you?                      YES                      NO

**REIMBURSEMENT RECEIVED**

**Property Insurance**

NAME OF INS. CO.	ADDRESS	POLICY NUMBER	VALUE
			\$

**Hospital/Medical** .....

\$
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**Restitution Received** .....

\$
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**Other Reimbursement** .....

\$
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**TOTAL REIMBURSEMENT** \$ \_\_\_\_\_

**NET LOSS RESTITUTION: \$** \_\_\_\_\_  
 (TOTAL LOSS minus TOTAL REIMBURSEMENT)

Attach additional pages if necessary.

\*\*\*\*\*  
 SIGNATURE

By signing this form, I swear that the above information is true and accurate to the best of my knowledge.

Signature of Victim

Date

**REMEMBER!**

If restitution is ordered in this case, you must keep the Clerk of the Court advised of your current address until paid in full.

Please sign and return this form within 10 days, or bring with you to court.

**Victim-Witness Assistance Program**  
 Post Office Box 40  
 Yorktown, VA 23690  
 vw@yorkcounty.gov