

Charles County State's Attorney's Office

P. O. Box 3065

La Plata, Maryland 20646

(301) 932-3350

(301) 870-3413

RESTITUTION REQUEST FORM

Defendant: _____ Case No.: _____

Victim/Complainant: _____

PROPERTY LOSS AND/OR MEDICAL EXPENSES:

A. Damages Suffered:

- 1. Value of property stolen/damaged: \$ _____
- 2. Hospital/medical bills: \$ _____
- 3. Out-of-pocket expenses: (List type and amount)
- _____ \$ _____
- _____ \$ _____
- _____ \$ _____
- _____ \$ _____
- _____ \$ _____
- _____ \$ _____
- Total Loss** \$ _____

B. Reimbursement Received:

- 1. Insurance Payment: Claim Number _____ \$ _____
- Company Name: _____
- Agent: _____
- Address: _____
- _____
- Telephone: _____
- _____

C. Expenses Not Reimbursed: \$ _____

Signature: _____ Date: _____

Address: _____

Telephone _____

Claims must be supported with documentation such as receipts, bills, written estimates and/or cancelled checks.

Please return this information upon receipt.