DOUGLAS COUNTY DISTRICT ATTORNEY'S OFFICE
CRIME VICTIM IMPACT STATEMENT

VICTIM'S NAME: _____

ADDRESS: _____

EMAIL ADDRESS: _____

PHONE (Home)_____(Work) _____(Cell) _____

NAME OF PERSON OTHER THAN VICTIM COMPLETING FORM: _____

RELATIONSHIP TO VICTIM: _____

DEFENDANT'S NAME: _____

DATE CRIME OCCURRED: _____

1. In your own words, briefly describe the crime committed against you and/or your family (Additional pages can be attached to answer this or any of the following questions.)

_____

_____

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2. If you were physically injured because of this crime, did your injuries require medical attention? _____

If yes, please describe the injury.

_____

_____

_____

What medical facility treated your injuries and how long was or will the treatment be needed?

_____

_____

3. Were you or your family emotionally impacted because of this crime? _____ If yes, how?

_____

_____

_____

_____

_____

_____

_____

(OVER)

FINANCIAL LOSSES THAT YOU ARE SEEKING RESTITUTION FOR:

TYPES OF LOSS	AMOUNT PAID BY YOU	AMOUNT PAID BY INSURANCE
MEDICAL BILLS ☐		
COUNSELING ☐		
PROPERTY DAMAGE ☐		
PROPERTY LOSS ☐		
CHECK FRAUD ☐		_____
FINANCIAL CARD FRAUD ☐		_____
	TOTAL: $	TOTAL: $

INSURANCE COMPANY INFORMATION (IF APPLICABLE)

NAME: _____

PHONE: _____

POLICY NO.:_____

4. Have you been informed of the Georgia Crime Victim's Compensation Program? _____ If so, have you completed and submitted an application? _____ Visit crimevictimscomp.ga.gov for more information.

5. Please share any additional views you would like to express.

_____

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This Victim Impact Statement is signed and affirmed as true under the penalties of perjury.

Signature: _____ Date: _____

MAIL/FAX/DROP OFF TO: **DOUGLAS COUNTY DISTRICT ATTORNEY'S OFFICE**
VICTIM/WITNESS PROGRAM
8700 HOSPITAL DRIVE, 2ND FLOOR
DOUGLASVILLE, GA 30134
FAX: (678) 838-2075

OR EMAIL DIRECTLY TO: **_____@CO.DOUGLAS.GA.US**