Clatsop County District Attorney Victim Services
PO Box 149 ● 749 Commercial Street
Astoria, Oregon 97103
(503) 325-8581

da@co.clatsop.or.us

Name _____
Address _____
City & State _____
Phone: _____

PERSONAL INJURY LOSS
NOTE: If you want the judge to order the defendant to pay restitution, you must provide us proof of your loss if available.

Defendant _____
DA Case No. _____

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1). Brief description of your injury: _____

2). Medical Expenses (list all hospital, doctor, ambulance bills, and/or prescription costs):

Doctor/Hospital	Description	Amount
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____

3). Lost wages: Yes/No (circle one)
If yes, please fill out following:

Occupation_____ Employer's name: _____
# of days missed from work: _____ Sick/vacation time used: _____
Total Amount of lost wages: _____

4). Do you anticipate any further expenses as a result of your injury/loss? _____

Total Loss Amount: $_____

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5). **Insurance:** If insurance may help cover your losses, please complete the following:
Insurance Company_____ Claim No._____
Contact Person_____ Phone_____
Amount actually paid/to be paid by insurance $_____ Your deductible$_____

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Please check proper box. Sign and date form.

[ ] No restitution is requested in this matter.

[ ] Restitution is requested in this matter.

[ ] Defendant's insurance has paid all expenses.

[ ] Supporting documents enclosed.

_____ _____
Signature Date

Please respond with all of your restitution information as soon as possible via email or the mailing address above.
If you do not, the court may not have sufficient information to order restitution from the defendant.