



# VICTIM IMPACT STATEMENT

Victim/Witness Unit  
Kalamazoo County Prosecutor's Office  
227 West Michigan Avenue, Kalamazoo, MI 49007  
(269) 383-8677

**Please use blue or black pen when completing this form.**

Defendant's Name: \_\_\_\_\_ Police Report No. : \_\_\_\_\_

Name of Parent or Guardian: \_\_\_\_\_

Name of Child: \_\_\_\_\_ Case No. \_\_\_\_\_

**What is your current phone number?**

The purpose of this Victim Impact Statement is to give you the opportunity to express your feelings about being a victim and to make the Court aware of the losses you have suffered in this criminal matter. **NOTE: This document will be shared with the Sentencing Judge, Prosecuting Attorney's Office, Defense Attorney and/or the Defendant.** If you need additional space, please feel free to attach extra pages. You may add to this statement at any time.

***Please feel free to add additional pages if you need more space to answer any of the questions. Thank you.***

1) How has this crime affected your child, you and others close to you? You may wish to discuss how the crime has affected relationships, your ability to perform work duties, run a household or enjoy activities you and your child enjoyed before the crime. You may also wish to include any victim services or counseling by either a licensed professional, member of the clergy or a community support group that you and your child have received.

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2) Has this crime affected the way your child relates to his or her friends, either at school or in your neighborhood? Has this crime affected your child's school work in any way?

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3) **PHYSICAL OR EMOTIONAL INJURY:** Describe in specific detail any physical injuries that your child received and/or medical treatment your child received as a result of this crime. **Attach copies (NOT originals) of any medical bills.** *If you plan to seek medical treatment, please describe below.*

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Did your child seek medical attention?  Yes  No If yes, where? \_\_\_\_\_

Do you have health insurance (i.e., Medicaid, Blue Cross, etc.)?  Yes  No  
If yes, who is your health insurance provider? \_\_\_\_\_

Did your health insurance cover your loss?  Yes  No  
If no, why not? \_\_\_\_\_

Have you applied for Crime Victim's Compensation?  Yes  No

Did your child receive counseling?  Yes  No  
If yes, where? \_\_\_\_\_

**Cost of Counseling: \$** \_\_\_\_\_

4) **OTHER FINANCIAL LOSS:** The court **may** consider lost wages, travel costs, and other related financial losses. **Wages:** List the days and hours you missed from work because of this crime and the amount of wages that you lost. **You must attach documentation of your lost wages from your employer.** **Travel:** If you are requesting reimbursement for travel costs (not already compensated for), please indicate the dates of travel, to/from location, total miles, and reason for travel.

\_\_\_\_\_  
\_\_\_\_\_  
Name of Employer: \_\_\_\_\_ Phone No.: \_\_\_\_\_

**Other Financial Loss Total: \$** \_\_\_\_\_

<b><u>RESTITUTION SUMMARY</u></b>	
<b>GRAND TOTAL DUE TO VICTIM: \$</b> _____ (out-of-pocket loss, co-pay and deductible)	
HOMEMAKING OR CHILD CARE EXPENSES (caused by medical injury) \$ _____	
TOTAL PAID BY MEDICAL INSURANCE: \$ _____	
<b>GRAND TOTAL: \$</b> _____	

Would you like to speak at sentencing?  Yes  No

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you are completing this statement for someone else, please provide the following information:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**PLEASE MAIL THIS COMPLETED FORM TO THE ADDRESS LOCATED AT THE TOP OF PAGE 1**