

THE CIRCUIT COURT OF THE THIRTEENTH JUDICIAL CIRCUIT  
OF THE STATE OF FLORIDA IN AND FOR HILLSBOROUGH COUNTY  
CRIMINAL JUSTICE DIVISION

STATE OF FLORIDA

CASE NUMBER: \_\_\_\_\_

VS

\_\_\_\_\_(Defendant)

DIVISION: \_\_\_\_\_

A Child

**VICTIM'S IMPACT STATEMENT**

Victim's Name: \_\_\_\_\_

**Fill out this next section if Victim is a Minor or name of next of kin (if victim deceased).**

Name of Parent/Guardian/Next of Kin \_\_\_\_\_

1. **RESTITUTION**

Are you requesting restitution? \_\_\_\_\_

**If yes, please attach copies of bill, receipts or estimates documenting your injury or losses. DO NOT SEND ORIGINAL BILLS.**

Total Amount of Restitution requested: \$ \_\_\_\_\_

Number of bills and receipts attached: \_\_\_\_\_

2. **PHYSICAL INJURIES**

Did you receive injuries which required medical treatment? YES or NO \_\_\_\_\_

If yes, describe your injuries:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Name of Hospital if hospitalized: \_\_\_\_\_

Did you receive any psychological services? \_\_\_\_\_

List all other medical services or medical devices as a result of this Crime:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Total cost of medical treatment: \$ \_\_\_\_\_

3. PROPERTY STOLEN OR DAMAGED

List all damaged or stolen as a result of this crime:

Item	Damaged	Stolen	Repair or Replacement Cost

NOTE: You may attach an additional document to list other items. Please indicate whether stolen or damaged and the cost of repair replacement if not recovered.

4. LOST INCOME

Days missed from work as a result of this crime:

Number of days:		Rate of pay:		/hr.
Total amount of loss income:			\$	
<i>(Attach proof of income)</i>				

5. INSURANCE

Do you have insurance to cover your injuries, losses or expenses? \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Claim Number: \_\_\_\_\_ Amount of Deductible: \$\_\_\_\_\_

Is there any other coverage of your expenses such as Medicare, Crimes Compensation, etc.? \_\_\_\_\_

If yes, list source: \_\_\_\_\_

Amount received: \$\_\_\_\_\_

6. VICTIM COMMENTS

This is your opportunity to let the Court know how this crime has affected you or your family and what hardships you have experienced as a result of this crime. You may include pain and suffering, inconvenience or change in your lifestyle. Attach additional sheets if necessary.

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7. RECOMMENDATIONS FOR SENTENCING

Please state any recommendation that you may have as to the sentence imposed by the Court. The recommendation may include: imprisonment, probation, fines, community service, counseling or other conditions you feel are appropriate. The actual length of the sentence a defendant may receive will be based on statutory minimums and maximums and sentencing guidelines established by the Florida Legislature:

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Signature \_\_\_\_\_

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

Print Name \_\_\_\_\_

Phone: \_\_\_\_\_

Mail or Return:  
State Attorney's Victim Assistance Office  
419 N. Pierce Street, 3rd Floor  
Tampa, Florida 33602-4022