STATE OF IDAHO vs. _____

CASE NUMBER: CR05-_____

PROPERTY TAKEN:
(include bad checks, fraud, forgery, etc. Attach an additional sheet if necessary)

1 _____
Market Value: $_____ Replacement Cost: $_____ Recovered: Yes/No

2 _____
Market Value: $_____ Replacement Cost: $_____ Recovered: Yes/No

3 _____
Market Value: $_____ Replacement Cost: $_____ Recovered: Yes/No

4 _____
Market Value: $_____ Replacement Cost: $_____ Recovered: Yes/No

Covered by Insurance: Yes/No
** Market Value is your estimate of what the item could have been sold for at the time it was taken, damaged or destroyed.

MARKET VALUE TOTAL: $_____

REPLACEMENT COST TOTAL: $_____

PROPERTY DAMAGES:
(Broken window, damaged automobile, etc.)

1 _____
Repair Cost: $_____ Covered by Insurance: Yes/No

2 _____
Repair Cost: $_____ Covered by Insurance: Yes/No

3 _____
Repair Cost: $_____ Covered by Insurance: Yes/No

4 _____
Repair Cost: $_____ Covered by Insurance: Yes/No

PROPERTY DAMAGE TOTAL: $_____

MEDICAL EXPENSES:
(attach additional sheets if necessary. If possible, include explanation of benefits)

Provider:	Description:	Cost:	Covered by Insurance: If yes, state amount or percentage

Medical Subtotal: $ _____

PLEASE ATTACH COPIES OF BILLS, RECEIPTS OR ESTIMATES

***GRAND TOTAL:** $ _____ ***

LOST WAGES

IF ANY TIME WAS LOST FROM YOUR WORK AND IT WAS DIRECTLY RELATED TO THE CRIMINAL ACT, PLEASE COMPLETE THIS FORM.

EMPLOYER: _____

ADDRESS: _____

CITY/STATE: _____

PHONE: _____ HOURS LOST: _____

DATES OF LOSS: _____

JOB TITLE: _____

TYPE OF WORK: _____

WAGE $_____ PER _____ TOTAL: $_____

Supervisor or person to contact for verification: (Please include an address or phone number where he/she may be reached.)

_____

_____

PLEASE COMPLETE THIS SECTION IF YOU HAVE BEEN OR WILL BE COVERED BY INSURANCE FOR ANY PART OF YOUR LOSS

INSURANCE COMPANY/AGENT _____

INSURANCE SUBSCRIPTION NUMBER: _____

ADDRESS/PHONE _____

What is your total claim? $_____

What is the amount of your deductible? $_____

What payment have you or will you receive from your insurance company? _____

_____

I HEREBY CERTIFY THAT THE ABOVE IS TRUE AND CORRECT.
DATED this _____ day of _____, 20_____.

Name (printed): _____

Signature: _____

***PAGE TOTAL: $_____ ***