GOVERNMENT OF BERMUDA
Ministry of Justice
Department of Public Prosecutions
Witness Care Unit

TO BE COMPLETED BY VICTIM

Name of Victim *(please print)*

Name of Offender *(please print)*

Harm done and loss suffered by you

Please describe the physical and or emotional loss suffered by you this may include the injuries and the treatment you received, including any permanent disabilities. Also include any material damage suffered by you. *(Please attach extra sheets if needed).*

Signature of Victim _____ Date _____

Received by: _____ Date: _____

Witness Care Officer

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TO BE COMPLETED BY VICTIM

Name of Victim *(please print)* _____ Name of Offender *(please print)* _____

Financial Impact
Please list any financial loss you may have suffered as a result of this incident. For example, medical expenses not covered by insurance, lost wages, any property that was damaged, destroyed or lost, the value of that property. Please attach copies of all bills, receipts or estimates you may have. (*Please attach extra sheets, if needed.*)

_____
_____
_____
_____
_____

(Please tick the appropriate box below)

☐ I,_____ give permission for the court to read this statement into evidence.

OR

☐ I,_____ believe this statement discloses confidential and/or sensitive information that may cause me or my family embarrassment or distress therefore request it not be read in court.

IF YOU HAVE COMPLETED THIS STATEMENT ON BEHALF OF THE VICTIM, PLEASE INDICATE WHY, AND WHAT YOUR RELATIONSHIP IS TO THE VICTIM.

PLEASE PRINT YOUR FULL NAME

_____
Family Name *First Name* *Relationship*

Reason:

_____
_____

The statements I have made are true to the best of my knowledge.

Signature of victim or person completing form: _____

Date: _____

Received by: _____ Date: _____
Witness Care Officer

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TO BE COMPLETED BY VICTIM

Name of Victim *(please print)*

Name of Offender *(please print)*

CONTINUATION SHEET

Signature of Victim _____ Date _____

Received by: _____ Date: _____

Witness Care Officer