CVR#_____

LOUISIANA CRIME VICTIMS REPARATIONS BOARD

PROVIDER CERTIFICATION FOR A VICTIM OF CRIME

CVR Office: (225) 342-1749 | Nationwide Toll-Free (888) 6-VICTIM | https://lcle.la.gov/programs/cvr/

In order for your application to be processed, you must complete all information on this application. ***PLEASE PRINT!*** You have one year from the date of the crime to file this application. If you are filing later than one year, you must attach a letter of explanation. Please remember, the Crime Victims Reparations Board is **NOT** responsible for your bills.

Please fill out this application completely.

VICTIM/SECONDARY VICTIM INFORMATION

Victim (or secondary victim) Name: First: _____ Middle: _____ Last: _____

Please check if secondary victim: ☐ yes ☐ no

Victim (or secondary victim) Date of Birth: _____ Date of Crime: _____

Victim age at time of crime: _____

Type of Qualifying Violent Crime(s): _____

Did the offense occur in Louisiana? ☐ yes ☐ no Parish where crime occurred: _____

Address/location where crime occurred: _____

Was the crime reported to law enforcement: ☐ yes ☐ no If yes, Police Department: _____

Item number: _____

INFORMATION FOR PROVIDER DOING CERTIFICATION

Provider Name _____ Agency: _____ Phone _____

Provider Workplace Address _____
(Street, City, State, & Zip Code)

Discipline:

☐ Attorney ☐ Doctor/MD ☐ Law Enforcement ☐ Licensed Clinical Social Worker ☐ Licensed Professional Counselor

☐ Other: _____ Louisiana License/Bar Number:_____

Louisiana Commission on Law Enforcement
Crime Victims Reparations
P.O. Box 3133
Baton Rouge, LA 70821

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VICTIM OF CRIME CERTIFICATION

Please provide a brief summary of the incident and victim's involvement (PLEASE PRINT LEGIBLY, OR TYPE):

Describe any injuries (physical or emotional) the victim sustained from the crime (attach medical documentation if applicable):

What is your relationship to victim (i.e., victim's doctor, counselor, etc.)?

What date(s) did the victim report this crime to you:

☐ I certify, subject to the penalty of fine and/or imprisonment, that all the information provided on this form is true and correct to the best of my knowledge.

Provider Signature (to be signed in original blue ink):

_____ **Date:** _____

Print Name:

_____ **Date:** _____

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