

**MEDICAL EXCUSE FROM JURY DUTY  
BASED ON SERIOUS HEALTH CONDITION**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient Address

Scheduled to appear for jury duty on: \_\_\_\_\_

**PATIENTS SHOULD COMPLETE THE ABOVE SECTION, THEN ASK THEIR DOCTOR TO COMPLETE BELOW.**

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**Dear Doctor:**

*The patient identified above is scheduled to appear for jury duty on the dates indicated. Serving one's community as a juror is a fundamental obligation of all citizens, and is the bedrock upon which our system of justice is based. In order to participate as a juror, an individual generally must be able to do the following:*

- *Appear in person at the courthouse*
- *Cognitively be able to receive and evaluate information that is presented during the proceeding*
- *Sit quietly during the proceeding, for periods of approximately two hours without a break, which may continue the entire day (and some trials may last more than one day)*

*Individuals who believe that they cannot successfully participate in jury duty due to their health condition must have their physician certify that a serious health condition prevents them from fulfilling their legal obligation to appear for jury duty.*

**WE ARE NOT REQUESTING ANY SPECIFIC DETAILS ABOUT AN INDIVIDUAL'S HEALTH OR MEDICAL CONDITION(S).  
PLEASE DO NOT PROVIDE MEDICAL RECORDS OR MEDICAL INFORMATION.**

**PLEASE COMPLETE THE CERTIFICATION BELOW**

*I hereby swear and affirm that the individual identified above is my patient, and that he/she has a serious medical condition at the present time that prevents him/her from being able to appear for jury duty. The duration of this serious medical condition is (please select one):*

\_\_\_\_\_ *Permanent; jury service in the future will not be possible.*

\_\_\_\_\_ *Temporary; jury service in the future may be possible (please estimate when: \_\_\_\_\_).*

*If you have approved this patient to go to work, please explain why it would be more detrimental for him/her to serve on the jury than to go to work. \_\_\_\_\_*

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's License No.

\_\_\_\_\_  
Practice Name

\_\_\_\_\_  
Practice Phone No.

**NOTE:** *We are happy to provide accommodations to potential jurors who may need an accommodation for a disability. If you or your patient feel that an accommodation may facilitate participation on jury service, please have your patient discuss their requested accommodation with the jury manager.*

*If you have any questions about this form, please call the Jury Manager at your County Clerk's Office.  
Feel free to attach additional pages if you need more space.*