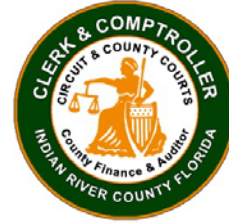


JEFFREY R. SMITH, CPA, CGFO, CGMA

Clerk of Circuit Court & Comptroller
P.O. Box 1028
Vero Beach, FL 32961-1028
Telephone: (772) 770-5185



EXCUSAL/POSTPONEMENT OF JURY DUTY FOR MEDICAL REASONS

THIS FORM MUST BE SIGNED BY A PHYSICIAN OR NURSE PRACTITIONER. **10 days** before the Juror/Patient is to report for jury duty, this request must be emailed to clerk@clerk.indian-river.org or faxed (772-581-4987), or hand delivered to the Jury Clerk. It is the responsibility of the Juror/Patient to assure this request is received by the Jury Clerk in a timely fashion.

Date: _____ Juror/Patient Name: _____

Pool & Juror Number: _____ Date Juror is to report for Jury Duty: ____/____/____

Juror Contact phone number _____

Name/Address/Office Phone/Fax Number of Healthcare Provider:

The undersigned states in good faith that the Juror/Patient has a medical condition that prevents the Juror/Patient from serving on a jury at this time because the medical condition prevents the Juror/Patient from sitting for long periods time even if the Juror/Patient is allowed to freely stand and stretch, is unable to comprehend information, or makes it difficult to see or hear evidence. The undersigned further states that the medical condition makes it inadvisable for the Juror/Patient to serve.

Please mark one and state condition of Juror/Patient on line for each:

_____ temporarily, and juror/patient should be able to serve after (please provide date) _____

_____ the juror/patient is physically infirm, and it is unknown when jury service will be possible (please explain):

_____ permanently, because the following mental illness, intellectual disability, senility, or other physical or mental incapacity makes the juror/patient incapable of caring for himself or herself (please explain in detail why this condition prevents serving on a jury):

***NOTE: Depending on the reason given for the permanent excusal, the judge may request the Department of Motor Vehicles to re-examine the juror's eligibility for driving privileges.**

(Signature of Physician/Nurse Practitioner)
Florida License Number: _____

(Printed Name of Physician/Nurse Practitioner)

(Date)

Official Use Only	G	D	P	Z	Rsch	Judge	Date
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