**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](mailto: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:**

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**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)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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*\_\_\_\_\_\_* temporarily, but it is unknown at this time as to when Juror/Patient will be able to serve in the future.

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*\_\_\_\_\_\_* permanently, F.S 40.013(9) states: Any person who, because of mental illness, intellectual disability, senility, or other physical or mental incapacity**, is permanently incapable of caring for himself or herself** may be permanently excused from jury service upon request *if the request is accompanied by a written statement to that effect* from a physician licensed pursuant to chapter 458 or 459.

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***\*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.***

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*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*(Signature of Physician/Nurse Practitioner) (Printed Name of Physician/Nurse Practitioner)*

*Florida License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*(Date)*

**Official Use Only** G\_\_\_\_ D\_\_\_\_ P\_\_\_\_Z\_\_\_\_ Rsch\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Judge\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_­­­\_\_