OSCEOLA COUNTY JURY SERVICES DEPARTMENT

REQUEST TO BE EXCUSED FROM JURY SERVICE FOR MEDICAL REASONS

Juror Name: ____ Badge #: _________________ Juror Service Date: ___/___/___

I authorize ___________________ (medical provider) to disclose any of my protected health information to the Ninth Judicial Circuit for purposes of determining whether I can be excused or disqualified from jury service. (Patient **MUST** sign HIPAA release below)

____________________________________ ____________________________________ ___________

Signature of Patient Printed Name of Patient Date

Healthcare Provider Information

(Section below **MUST** be completed and signed by a physician or a nurse practitioner)

Name of Healthcare Provider: ____ Treating juror since: ___/___/___

Address: ____

City: ____ State: ________________ Zip: _____________________

Phone: ____ Fax: ____

Note to Physician/Nurse Practitioner: When completing this form, please consider that Jurors are not required to stand for long periods, typically sit in the courtroom for no more than 1-1 ½ hours, and are able to stand or reposition themselves as needed for comfort. The court will make ADA accommodations upon request and will permit jurors to take breaks as needed.

Please select only one and state the condition of Juror/Patient on the available line:

☐ **Temporary excusal or deferral:** Juror/Patient should be able to serve after (please provide date):

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☐ **One-time excusal:** It is unknown at this time if/when Juror/Patient will be able to serve in the future. Will need to reassess Juror/Patient's medical condition when summoned again**. (PLEASE EXPLAIN WHY CONDITION PREVENTS JURY SERVICE).**

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☐ **Permanent excusal or disqualification:** The following medical condition will never improve during the rest of the Juror/Patient's life. **(PLEASE EXPLAIN WHY CONDITION PREVENTS JURY SERVICE.)**

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The undersigned states in good faith that the Juror has a medical condition that prevents the Juror from serving on a jury at this time. This medical condition prevents the Juror from serving due to mental illness, intellectual disability, senility, or other physical or mental incapacity.

____ ____

Signature of Physician/Nurse Practitioner Printed Name of Physician/Nurse Practitioner

Florida License No: _________________________ Date: ____________________________________

***This request must be emailed, faxed, or mailed 10 days prior to the date Juror is to report to the courthouse. It is the sole responsibility of the Juror to ensure this request is received in a timely manner.** **Email: osceolajury@ocnjcc.org** **Fax: (407) 742-2630**

Mail to: Ninth Judicial Circuit, Osceola County, Attn: Jury Services, 2 Courthouse Square Suite 1100 Kissimmee, Florida 34741.