MEDICAL EXCUSE FROM JURY DUTY
BASED ON SERIOUS HEALTH CONDITION

_____
Patient Name Date of Birth Scheduled for jury duty on: _____

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

***Dear Doctor**:*

The patient identified above is scheduled for jury duty on the dates indicated. Iowa law makes jury service a fundamental obligation of all citizens, and the bedrock of our court system. Jurors must be able to:

- *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 serve on jury duty due to their health must have their health care provider certify that a serious health condition prevents them from fulfilling their legal obligation to appear for jury duty.

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

<u>PLEASE COMPLETE THE CERTIFICATION BELOW</u>

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 nature of this condition requires my patient to be exempt from jury service for the following period of time:

____ *Short-term: Please estimate when jury service is possible within the next twelve months: _____.*
____ *Mid-term: Excuse from service this cycle. Patient will be able to serve upon becoming eligible again in two years.*
____ *Long-term: Forever (Requires certification as to what aspect of jury duty is not possible due to the patient's condition. E.g., "Patient condition prevents him from sitting more than one hour at a time").*

_____

If you have approved this patient to go to work, please indicate 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.

<u>NOTE</u>: 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.