

**AFFIDAVIT FOR EXEMPTION FROM JURY DUTY
FOR PHYSICAL OR MENTAL IMPAIRMENT**

Government Code Section 62.109 allows for a permanent or temporary exemption from jury service based upon a physical or mental impairment. The exemption may only be granted by court order once an affidavit and physician's statement is received from the prospective juror. Please complete the affidavit and physician's statement and mail them to the Court Clerk for submission to the Court. You will be notified if your request is denied. ****Please understand that once a judge makes a ruling; the Court Clerk cannot modify or change the decision.****

Govt. Code 62.109(b) A person requesting an exemption under this section must submit to the court an affidavit stating the person's name and address and the reason for and the duration of the requested exemption....

Applicant's Name: _____ Juror No.: _____

Applicant's Full Address: _____

Date of Birth: _____ Daytime phone: _____

Evening Phone: _____ Email: _____

Are you currently working? ☐ YES or ☐ NO

If yes, please list occupation & employer: _____

*Applicant requests exemption for the following, specific condition(s) **(REQUIRED)**:

(Listing only "medical" is not sufficient, and will not be accepted.)

Exemption requested: (Please check one)

☐

PERMANENT

☐

TEMPORARY

Applicant states: "I am aware that jury service is not necessarily physically difficult, however, as a direct result of my physical or mental impairment, it is impossible or very difficult for me to serve on a jury."

A physician's statement **MUST** be attached to this affidavit. The name and address of the physician is:

Name: _____

Address: _____

PLEASE NOTE THE FOLLOWING:

This affidavit must be completed in its entirety, with specific conditions(s) for requesting exemption listed, and signature of applicant OR applicant's designee **must be notarized**. Once completed it may be hand delivered OR mailed to Wood County District Clerk Attn: Juror Responses, PO Box 1707, Quitman, TX 75783 along with the accompanying physician's statement. ***Incomplete affidavits will NOT be submitted to the court.***

STATE OF TEXAS
COUNTY OF WOOD

"I _____, on my oath state the above and foregoing statements are within my knowledge true and correct."

Signature of Applicant or Applicant's Designee

Subscribed and sworn before me the undersigned this _____ day of _____,
20 _____.

Notary Public

ORDER

The above affidavit for exemption from jury duty was presented to the _____ Court of Wood County, Texas. The Court orders that the request for exemption should be _____ **granted** _____ **denied**. If granted, the applicant will be exempt from jury duty in the justice, county and district courts of Wood County, Texas for the period of time specified by the Physician's Statement.

Signed this _____ day of _____, 20 _____.

Presiding Judge

PHYSICIANS STATEMENT FOR MEDICAL EXEMPTION FROM JURY DUTY

Govt. code 62.109 (b). A person requesting an exemption under this section must submit to the court an affidavit stating the person's name and address and the reason for and the duration of the requested exemption. **A person requesting an exemption due to a physical or mental impairment must attach to the affidavit a statement from a physician.**

Please have this statement completed, attach to the sworn affidavit and return affidavit along with your jury summons/questionnaire and return to the DISTRICT CLERK.

(Statements need to be submitted to our office at least 4-5 business days PRIOR to your appearance date.)

(This section to be completed by the prospective juror.)

Name of person applying for exemption: _____

Address of person applying for exemption: _____

Juror No. _____ Date expected for service: _____

(This section to be completed by the physician**)**

Physicians Name: _____

Physicians Address: _____

Physician's Phone No. _____

I do hereby certify that _____

is under my care for a physical or mental impairment, and it is impossible or very difficult for him/her to serve on a jury because of the specific condition(s) listed below **(required)**:

Please check one of the following for the length of the exemption:

_____ Permanent _____ Temporary

If this is a temporary medical exemption, please give the length of time for the exemption:

Signed this _____ day of _____, 20_____.

Signature of Physician