



## NOTICE TO PROSPECTIVE JURORS WITH DISABILITY OR MEDICAL CONDITION

NAME:  
ADDRESS:  
CITY/STATE/ZIP:

**Please return form to:**  
Cameron County District Clerk  
Jury Administration Office  
974 E. Harrison St.  
Brownsville, Texas 78520

Your response to the jury administrator indicates a disability or medical claim. Present this form to your physician to be completed.

The completed form must be returned to our office before you are given a scheduled appearance date or your name will remain on the jury summons list with a non reporting status. When the form is received, the judge will review it and take the appropriate action.

If your claim is approved, the jury administrator will contact you. If your claim is denied, you will need to appear on the scheduled date unless you are called earlier by our office.

I authorize my physician to release the following medical information regarding my health.

\_\_\_\_\_  
JUROR SIGNATURE

\_\_\_\_\_  
JUROR PHONE NO

\_\_\_\_\_  
DATE

### INSTRUCTIONS TO PHYSICIAN

**Please complete, sign and return to your patient.**

The above named person is a patient of mine and he/she suffers from the following illness/disability which would preclude him/her from serving on jury duty at this time: (Please use bottom three lines for illness/disability)

In my medical opinion he/she (check one)

\_\_\_\_ will be able to serve in 90 days.

\_\_\_\_ will be able to serve in 6 months.

\_\_\_\_ will be able to serve in 1 year.

\_\_\_\_ will not be able to serve for 1 or more years.

\_\_\_\_\_  
Physician's Name (Please Print)

\_\_\_\_\_  
Physician's Address

\_\_\_\_\_  
Physician's Telephone

I state to the Court that the above information is true and correct.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

### FOR OFFICIAL USE ONLY

\_\_\_\_ deferred 90 days

\_\_\_\_ deferred 1 year

\_\_\_\_ deferred 6 months

\_\_\_\_ EXCUSED

\_\_\_\_\_  
Judge Presiding

Juror notification:

Date: \_\_\_\_\_ By: \_\_\_\_\_ Comments: \_\_\_\_\_