CLAYTON COUNTY JUDICIAL CIRCUIT MEDICAL AFFIDAVIT

NOTE: THIS FORM MUST BE <u>COMPLETED</u> & CONTAIN <u>ALL</u> SIGNATURES IN ORDER TO BE CONSIDERED.

Juror Name	_ Juror #	Jury Service Date
Personally appeared before me, the undersigned witness, follows:	(Phys	who, under oath states as ician's Name)
PHYSICIAN: PLEASE COMPLET PERMANENTLY DISABLED		SECTION (NOT BOTH) TEMPORARILY DISABLED
Patient,	is of The (Inde The serv (Jur	ent, currently being treated by me for Days Weeks or Months. efinite time is not acceptable.) patient could be considered for jury ice after the time specified. or will be temporarily deferred for the th of time specified.)
PHYSICIAN'S SIGNATURE (REQUIRED) Sworn to and subscribed before me this		CIAN'S PHONE NUMBER, 20
SIGNATURE OF A WITNESS (REQUIRED)		OF WITNESS (Someone who works in the physician's .e., RN, RECEPTIONIST, ETC.)
I hereby swear or affirm that the above information pro acknowledge that the Office of the Clerk of Superior C information given.		
JUROR'S SIGNATURE (REQUIRED)	JURO	R'S PHONE NUMBER
In order for this form to be considered for a p Permanently Disabled section <u>or</u> the Temporaril and <u>ALL 3 signatur</u>	y Disabled s	ection must be filled out completely
The completed form may be delivered/mailed to the add completed form may be faxed to the number below; howe		
	o <mark>ffice.</mark> mons Jury D vd., Suite 1J 3A 30236-49	Division A01 Division