



New Jersey Judiciary Physician Certification in Support of Medical Excuse Request

Practice Name and Address	Physician's Name	
	Physician's Office Telephone Number	
	Physician's License Number	
Patient (Juror) Full Name	County	Candidate ID
Patient (Juror) Telephone Number	Patient (Juror) Email Address	Summons Date

I have examined the above named patient and attest that he/she is unable to serve when summoned. At this time, this patient is unable to serve for:

- | | |
|----------------|----------------------|
| _____ 3 months | _____ 12 months |
| _____ 6 months | _____ Over 12 months |
| _____ 9 months | _____ Other* |

**The Judiciary relies on disability determinations made by the Social Security Administration and Department of Veteran Affairs to permanently excuse a juror from their service obligation. Please contact the Jury Management Office if you have additional questions on medical excusals and disqualifications. The New Jersey Judiciary will, with advanced notice, provide accommodations consistent with the Americans with Disabilities Act. ADA contacts for each county can be found at: https://www.njcourts.gov/forms/12134_adatitleIIcontacts.pdf*

NOTE: Please do not write, attach, or otherwise provide any private health information about the patient. The Jury Management Office will *never* request this information.

If this patient is employed, please explain why it would be more detrimental for them to serve their term of jury service than their normal employment.

I hereby certify and say that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Date	Name of Physician (Print Name)
	Signature of Physician