Physician's Statement
for
Permanently Disabled Absentee Voter Status

Voter Name ________________________________

Date of Birth ________________________________

Physical Address ____________________________

City ____________ ***State*** ______ ***Zip***____________

Phone ___________________________________

I, __________________________________, am a duly licensed and practicing Medical
(printed name of Physician or Nurse Practitioner)
Doctor or Nurse Practitioner. I have personal medical knowledge of the above named individual and find that said individual is PERMANENTLY PHYSICALLY DISABLED to such a degree that it is difficult for him/her to vote in person. This statement is signed for the sole purpose of allowing said individual to vote by absentee ballot without necessity of reapplication pursuant to Section 23-15-629, Mississippi Code of 1972, as amended. Any use of said statement, including but not limited to any disability claim for any reason other than absentee voting, is forbidden.

Signed this the ___________ day of ___________, 20___.

____
Signature of Physician or Nurse Practitioner

____
Office Address

____
Phone