



## Shelby County Election Commission

### Application for Permanent Absentee Voting List

Directions: The voter should complete this page and have their physician complete the next page. When both forms are received, the voter will be added to the Permanent Absentee Voting List.

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
*Number and Street* *Apt.*

\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
*City* *State* *Zip*

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
*MUST have all 9 digits*

Phone: \_\_\_\_\_

*I request that my name be placed on the Permanent Absentee Voting List. I reside at the above address.*

Voter Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*Digital Signature NOT Accepted....Must be Original Signature*

<p>Assisting: _____ Date: _____ <i>Digital Signature NOT Accepted. Must be Original Signature</i></p> <p>Address: _____</p>	<p>Witness: _____ Date: _____ <i>Digital Signature NOT Accepted. Must be Original Signature</i></p> <p>Address: _____</p>
---	---

*If the voter cannot sign or make a mark, the signature and address of the person assisting them and a witness is required.*

Questions? Call us at 901-222-6800. Email this application to: [absenteevoting@shelbycountyttn.gov](mailto:absenteevoting@shelbycountyttn.gov) or mail to: Shelby County Election Commission, 980 Nixon Drive, Memphis, TN 38134

# Physician's Statement

This statement is submitted to the Election Commission of Shelby County, Tennessee pursuant to *Tennessee Code Annotated § 2-6-201930 (A)*, as follows:

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, and Zip Code: \_\_\_\_\_

I hereby certify that I am the above named person's licensed physician and due to a sickness, hospitalization or physical disability it is my professional medical judgement, that he or she is medically un able to appear at his or her polling location and is medically unable to go to the election commission office for the purpose of early voting.

It is my professional opinion that this patient is medically unable due to:

Sickness                       Hospitalization, or                       Physical Disability

This sickness, hospitalization, or physical disability is  Perpetual, or                       Temporary

If temporary, estimated date of recovery is: \_\_\_\_\_

I understand that this statement will be attached to the permanent registration record of the above mentioned person and that ***THIS STATEMENT IS SUBMITTED UNDER THE PENALTY OF PERJURY.***

This, the \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

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

\_\_\_\_\_  
*Name Typed or Printed*

\_\_\_\_\_  
*Street Address*

\_\_\_\_\_  
*City, State, and Zip Code*

\_\_\_\_\_  
*Phone Number*