Print Form

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

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

*Assisting:*_____ *Date:* _____	*Witness:*_____ *Date:*_____
*Address:*_____	*Address:*_____

Questions? Call us at (901) 222-6800. Email this application to: absenteevoting@shelbycountytn.gov or mail to:

Shelby County Election Commission, 980 Nixon Drive, Memphis, TN 38138

Physician's Statement

This statement is submitted to the Election Commission of SHELBY COUNTY, TENNESSEE pursuant to *Tennessee Code Annotated § 2-6-201(3) (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 judgment, that he or she is medically unable to appear at his or her polling place 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 _____, 2_____

_____ _____

Physician's Signature *Name Typed or Printed*

_____ _____

Street Address *City, State, and Zip Code*

_____

Phone Number