State Office of Administrative Hearings
P.O. Box 13025, Austin, Texas 78711-3025
Phone 512.475.4993 | Fax 512.522.5263

Medical Excuse Affidavit in Support of Motion for Continuance

Instructions to the Completing Physician: A motion requesting a continuance or delay of an impending legal proceeding at the State Office of Administrative Hearings has been made by the below-named party on the basis of illness. Your patient requests you to provide a physician's affidavit attesting to certain medical facts in support of their motion based on your medical expertise. Please complete the information on this form to the best of your knowledge and ability. The affidavit must be sworn and/or notarized by a Notary Public for the State of Texas.

_____,	§	**SOAH Docket Number:**
Petitioner	§	
	§	
v.	§	
	§	
_____,	§	
Respondent	§	
	§	
STATE OF TEXAS	§	
{_____}	§	
COUNTY		

_____ (Party), _____ (Name), submits this affidavit supporting the allegations in _____ (his/her) motion for continuance.

My name is _____ (Name of physician), the affiant, and I am the treating physician for _____ (Party name). I testify as follows:

1. "My name is _____ (Name of physician). I am over 18 years of age, of sound mind, and capable of making this affidavit. The facts stated in this affidavit are within my personal knowledge and are true and correct.
2. _____ (Party name) has requested a continuance of a scheduled proceeding on the basis that _____ (he/she) is unavailable due to illness or medical condition.

3. I attest to the following information based on my medical expertise: *(The physician's affidavit*

must address each of the listed matters below: (i) the nature and severity of the party's illness or medical condition; (ii) the date(s) of the scheduled hearing and whether the party is too ill to attend the hearing on the scheduled dates(s); (iii) whether the party's health may be jeopardized if the party attends the hearing; (iv) the prognosis for the party's recovery; and the date by when the party will be able to participate.)

(Attach a separate page for additional information if necessary.)

Physician Signature: _____

Physician Printed Name: _____

Phone Number: _____ Email Address: _____

ATTESTATION:

My name is _____ (First, Middle, Last) and my address is

_____

Street City State Zip Code

I declare under penalty of perjury that the foregoing is true and correct.

Executed in _____ (County), State of Texas, on the _____day of

_____ (Month), _____ (Year).