

**POWER OF ATTORNEY
WITH PHYSICIAN STATEMENT
ACKNOWLEDGED BEFORE AN ELECTION OFFICIAL**
R.C. 3501.382 (A)(1)(b)

Notice: The powers granted by this document are limited. You may revoke this power of attorney if you later wish to do so.

I, _____, by reason of disability, am unable to sign my name
Name of Voter

and hereby appoint:

| | |
|--------------------------|---|
| Name of Attorney in fact | Date of Birth |
| Residence Address | Ohio Supreme Court Registration Number (If applicable) |
| City and Zip | |

a legally competent resident of this state who is 18 years of age or older, as my attorney in fact to act for me in any lawful way with respect to the following subject:

Sign my name as a candidate, signer, or circulator on a declaration of candidacy and petition, nominating petition, other petition, or other documents under Title XVIII of the Revised Code at my direction and in my presence.

The form of signature my attorney in fact will use when signing my name is:

_____.

A photocopy of my attorney in fact's driver's license or state identification card issued under section 4507.50 of the Revised Code is attached to this notarized form.

Signed this _____ day of _____, _____.

Your Signature or Mark

PHYSICIAN'S STATEMENT

I, _____, hereby state that _____,
Name of Licensed Physician Name of Disabled Voter

is disabled, and by reason of that disability, is physically* unable to sign her/her name to petitions or other election documents.

_____.