

Letter Certifying Applicant's Gender Change

I, _____,
(Physician's Full Name)

_____, _____,
(Physician's medical license/certificate number) (Issuing State/Country of license/certificate)

am the physician of _____,
(Name of Patient)

_____.
(Date of Birth of Patient)

with whom I have a doctor/patient relationship and whom I have treated, or with whom I have a doctor/patient relationship and whose medical history I have reviewed and evaluated.

(Name of Patient)

has had appropriate clinical treatment for transition to _____.
(gender)

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

Signature of Physician

Physician's Address

Typed Name of Physician

Date

Physician's Phone Number