TO BE PRINTED ON OFFICIAL PHYSICIAN'S LETTERHEAD

REQUEST TO CHANGE GENDER DESIGNATION

TO BE COMPLETED BY A LICENSED PHYSICIAN

I attest to the following:

- I am a Licensed Physician and I have a doctor/patient relationship with _____. I attest that he/she is undergoing appropriate clinical treatment for gender transition to: *(check one)*

  ☐ **Male** ☐ **Female**

PHYSICIAN LAST NAME (please print)	PHYSICIAN FIRST NAME	PHYSICIAN PHONE NUMBER

PHYSICIAN ORGANIZATION NAME (if applicable)

PHYSICIAN STREET ADDRESS	CITY	STATE	ZIP CODE

ISSUING STATE OF MEDICAL LICENSE/CERTIFICATE	MEDICAL LICENSE/CERTIFICATE NUMBER	PHYSICIAN DRUG ENFORCEMENT ADMINISTRATION REGISTRATION NUMBER

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

SIGNATURE OF LICENSED PHYSICIAN	DATE SIGNED
X	

Non-verifiable medical license numbers or illegible forms will be rejected.

Submitted form must contain an original signature.