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