Declaration of Gender Transition or Intersex Condition by Licensed Health Care Professional

I, ____ being a licensed health care
(name of health care or mental health professional)

professional or a licensed mental health professional, have personally treated or evaluated

____ and this person has either:
(name of person treated or evaluated)

☐ undergone treatment that is clinically appropriate for the purpose of gender transition, based on contemporary medical standards or,
☐ has an intersex condition

The sex designation on such person's birth record should therefore be changed to ___________

PHYSICIAN'S INFORMATION

License number ________________ Issuing state ______________ Expiration __________

Office street address ____

Office city, state, and ZIP code ____

Office telephone ______________________ Office fax ____________________________

I attest that I have a provider/patient relationship with the minor and the requested gender designation is consistent with the minor's identity.

Signature ____
(Licensed health care professional or licensed mental health professional)

Date_____________________