Letter Certifying Applicant's Gender Change

I, _____,
(Physician's Full Name)

_____, _____,
(Physician's medical license number and State of license) (DEA number)

am the physician of _____,
(Name 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.

_____, has had
(Name of Patient)

appropriate clinical treatment for gender transition to the new gender of *(circle one)*

male female.

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

_____
Signature of Physician

_____
Name of Physician

_____
Date