GENDER REASSIGNMENT

SAMPLE TEMPLATE

(MUST BE PRINTED ON PHYSICIAN'S LETTERHEAD
AND SIGNED BY THE PHYSICIAN)

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)

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 appropriate
(Name of Patient)

clinical treatment for gender transition to the new gender of:

☐ 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)

_____
(Typed or Printed Full Name of Physician)

_____
(Date)