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 listed on the birth certificate)

- ☐ undergone treatment that is clinically appropriate for the purpose of gender transition, based on contemporary medical standards or,
- ☐ has an intersex condition or,
- ☐ the parent(s) opted for the X designation on the child's birth certificate at the time the birth record was created and the parent(s) would now like to change the gender marker to be consistent with the minor's gender identity.

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_______________

Revised 11/2024