

(Must be on official letterhead of physician that includes address and telephone number)

Date

To Whom It May Concern:

I, (name of physician), (state or other country and license or certificate number of the physician), 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).

(Name of patient) has had appropriate clinical treatment for gender transition to the new gender – (specify male or female).

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

Sincerely,

(Signature of physician)

(Typed name of physician)