

Licensed Physician's Letterhead
(Physician's Address and Telephone Number)

I, (physician's full name), (physician's medical license or certificate number), (issuing U.S. State/Foreign Country of medical license/certificate), am the physician of (name of patient), whom I have treated (or whose medical history I have reviewed and evaluated).

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

Or

(Name of patient) is in the process of transition to (specify new sex male or 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 Name of Physician

Date