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The Sample Health Care Certification starts on the next page

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Health Care Certification

Patient's Information

Full Name: _____

Date of Birth: _____

To Whom It May Concern:

I am a licensed _____.
(Counselor, nurse practitioner, physician, physician assistant, psychologist, social worker, or therapist)

I have treated or evaluated _____, in relation to
(Name of Patient)

_____'s gender identity.
(Name of Patient)

In my professional opinion, _____'s gender identity is consistent with a designation of: ◉ male ○ female.

Health Care Professional's Information

Full Name: _____

Organization (if any): _____

Address: _____

Phone Number: _____

License Type: _____

(Counselor, nurse practitioner, physician, physician assistant, psychologist, social worker, or therapist)

License Number: _____

Issuing State, Country, or other Jurisdiction of License: _____

Sincerely,

_____
(Health Care Professional's Signature)

_____
(Health Care Professional's Printed Name)