PRINTED ON PHYSICIAN’S LETTERHEAD

# 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)