



**Government of the District of Columbia  
Department of Health**



**Statement of Licensed Healthcare Provider Certifying the Applicant's Gender Change**

Name of Healthcare Provider: \_\_\_\_\_ Name of Applicant: \_\_\_\_\_  
(Print) (Print)

Address: \_\_\_\_\_  
(Healthcare Provider)

Telephone Number: \_\_\_\_\_ Email: \_\_\_\_\_ Fax: \_\_\_\_\_  
(Healthcare Provider)

I, \_\_\_\_\_ am a licensed healthcare provider (Licensed Physician, Licensed Osteopathic Physician, Licensed Psychologist, Licensed Independent Clinical Social Worker, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Nurse Practitioner) in good standing in (issuing US State/Foreign) \_\_\_\_\_.

My professional license/certificate number is \_\_\_\_\_.

I am the healthcare provider of \_\_\_\_\_ with whom I have a healthcare provider/patient relationship and whom I have treated or evaluated. I hereby certify and confirm that \_\_\_\_\_ has undergone surgical, hormonal or other treatment appropriate for the individual for the purpose of gender transition based on contemporary medical standards or the individual has an intersex condition. In my professional opinion, the individual's gender designation on their birth certificate should be changed to \_\_\_\_ Male \_\_\_\_ Female.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct and acknowledge and understand that any person who willfully or negligently makes a false certification is subject to civil fines, penalties and fees.

Signature of Healthcare Provider: \_\_\_\_\_

Print Name of Healthcare Provider: \_\_\_\_\_

Date: \_\_\_\_\_

Health Care Provider Office Stamp (If Available)

*Vital Records Division*

12/23/2013