CASE NO. _____

LICENSED PROFESSIONAL'S STATEMENT

To be completed by a physician, psychologist, therapist, nurse practitioner, or social worker who is licensed to practice in the United States that certifies the gender identity of the applicant.

Physician Psychologist Therapist Social Worker Nurse Practitioner

I,_____ _____ _____
LICENSED PROFESSIONAL FULL NAME **LICENSE/CERTIFICATE NO.** **ISSUING STATE**

am the physician of _____ , whose date of birth is
PATIENT NAME

_____ .

My professional opinion is that the patient's gender identity is _____ .

I certify that my practice includes the treatment and counseling of persons with gender identity concerns, including the applicant _____, who is my patient.
I certify under the penalty of perjury that all information on this form is true and correct.

_____ _____
Signature of Licensed Professional Date Signed

_____ _____
Typed Name of Professional Name of Hospital or Clinic

_____ _____
Phone Number Address

_____
City/State/Zip