I _____ ,

(Medical License or Certificate Number),

_____

(Issuing U.S. State/Foreign Country of License/Certificate),

_____

(DEA Registration number or comparable foreign designation),

_____

Am the physician of _____ (_____) , with whom I have a doctor/patient relationship and whom I have treated (or whom I have a doctor/patient and whose medical history I have reviewed and evaluated).

_____ has had appropriate clinical treatment for Gender Transition to the new gender _____ .

I declare under penalty of perjury under the laws of the United States that the forgoing is true and correct .

Signature :

_____

Typed Name :

_____

Date :