FORM FOR CHANGING SEX DESIGNATION

VIRGINIA DEPARTMENT OF HEALTH – DIVISION OF VITAL RECORDS
P. O. BOX 1000, RICHMOND VIRGINIA 23218

To be completed by the health care provider from whom the person received clinically appropriate treatment for gender transition.

I ____, am a licensed health care provider in good standing to
(Health Care Provider's Name)

practice ________________________________ in the state of _________________________. My professional
(Type of Provider) (Name of State)

license number is, ___________________. I am a health care provider for_______________________________
(License Number) Patient's Full Name)

born on ____________________ in __________________________, Virginia. ____________________________
(Patient's Date of Birth) (City/County) (Patient's Full Name)

has received treatment from me and undergone clinically appropriate treatment for gender transition. The sex

listed on the new birth certificate of ___________________________________ shall be changed to ___________.
(Patient's Full Name) (Male or Female)

The above information is accurate and true. Under Virginia Code § 32.1-276, it is unlawful to willfully and knowingly supply false information intending that such information be used in the preparation or amendment of any vital record.

Signature of Health Care Provider: ____________________________________ Date: __________________

Business Address of Health Care Provider: ____

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