**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.

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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)

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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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