

CHC Hilltop Medical Clinic

1202 Martin Luther King Jr. Way

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February 13, 2018

Re: *Preferred name (Legal name) Last name*

DOB: *xx/xx/xxxx*

To Whom it May Concern:

I, Dr. X, am the physician of LEGAL NAME (PREFERRED NAME) with whom I have a doctor/patient relationship and whose medical history I have reviewed and evaluated. The patient has had appropriate clinical treatment for gender transition to the new gender of MALE/FEMALE.

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

Sincerely,

*Your name here*, MD

License # XXXXXXXXX