

CHC Hilltop Medical Clinic

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August 15, 2017

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

DOB: *xx/xx/xxxx*

To Whom it May Concern:

I am a provider licensed to practice medicine in the state of Washington. *(Preferred name)* is a patient in my practice. He has a history of persistent gender dysphoria and has the capacity to provide informed consent. He has no significant uncontrolled medical or mental health conditions. *(OR his chronic conditions of \_\_\_ are reasonably well controlled.)* He has lived for more than 12 continuous months in the gender role that is congruent with his identity. He has been on gender affirming hormone therapy for over 12 months. I recommend him for masculinizing genital surgery.

Sincerely,

*Provider name*

License # *XXXXXXX*