

CHC Hilltop Medical Clinic

1202 Martin Luther King Jr. Way

Tacoma, WA 98405-3926

Phone: (253) 441-4742

Fax: (253) 442-8790

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October 3. 2019

Re: Preferred name (legal name) Last name

DOB:*0/00/0000*

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 been evaluated for the capacity to provide informed consent. He has no significant uncontrolled medical or mental health conditions. He not smoke cigarettes and his BMI is xx.xx*.* He has received the appropriate gender affirming medical treatment and has been on hormone therapy for over one year. I recommend him for masculinizing chest reconstruction.

Sincerely,

Provider, ARNP/DO/MD

License # *XX123456*