

CHC Hilltop Medical Clinic

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November 14, 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 (Legal name)* is a patient in our practice. She is a transgender female with a history of persistent gender dysphoria. She is able to make a fully informed decision and provide informed consent for treatment. Her chronic medical and mental health conditions are reasonably well controlled. She has undergone more than 12 continuous months of feminizing hormone *therapy (or “appropriate medical treatment for gender dysphoria” if no HT chosen)*. She has been living for 12 months in her congruent gender identity.

Sincerely,

Provider name

License # *XXXXXXX*