

Change of Gender Designation Request

You can use this form to request a gender designation change on your Washington driver license, instruction permit, identification (ID) card, enhanced driver license, or enhanced identification card. This form must be completed by you and a licensed health care provider (as noted in the Physician section below) familiar with your treatment. Send this completed form **and** a photocopy of your valid Washington driver license, instruction permit, identification card, enhanced driver license, or enhanced identification card to:

Programs and Services, Driver Records
Department of Licensing
PO Box 9030
Olympia WA 98507-9030

You will be notified in writing when your request has been processed. **Incomplete applications will not be processed.**

Applicant

TYPE or PRINT Name as it appears on your current license or ID card (<i>Last, First, Middle</i>)		License or ID card number
(Area code) Daytime telephone number	Email (<i>in case we need to contact you</i>)	
Answer the following		
What gender designation would you like on your license or ID card? <input type="checkbox"/> Male <input type="checkbox"/> Female		
<i>I authorize the licensed health care provider listed in the physician section to release information related to this request. I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.</i>		
Date and place signed	X	Signature

Physician

This section must be completed by a licensed medical physician, internist, endocrinologist, gynecologist, urologist, osteopathic physician, psychiatrist, psychologist, or a Washington State licensed naturopathic physician, advanced registered nurse practitioner, physician assistant, or certified osteopathic physician assistant familiar with your treatment.

TYPE or PRINT Name of patient			
Your name as it appears on your license			
License number	Expiration date	Issuing state/jurisdiction	DEA registration number
Hospital or medical clinic name			(Area code) Telephone number
Physical address (<i>Address, City, State, ZIP code, Country</i>)			
Mailing address, if different (<i>Address, City, State, ZIP code, Country</i>)			
Answer the following			
1. I am the attending health care provider with a doctor/patient relationship with the applicant. <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. I have reviewed and evaluated the applicant's medical history. <input type="checkbox"/> Yes <input type="checkbox"/> No			
3. The applicant has undergone the appropriate gender transition clinical treatment. <input type="checkbox"/> Yes <input type="checkbox"/> No			
4. What is the gender identification of this applicant? <input type="checkbox"/> Male <input type="checkbox"/> Female			

I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

Date and place signed	X
	Physician signature