[name]
[physician office, if applicable]
[address]
[telephone]

To whom it may concern:

I, [physician's full name], [physician's medical license or certificate number], [issuing U.S. State/Foreign Country of medical license/certificate], am the physician of [name of patient], with whom I have a doctor/patient relationship and whom I have treated.

[Name of patient] has had appropriate clinical treatment for gender transition to the new gender [specify new gender male or female].

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

[Signature]

[Typed Name]
[Date]