Changing the Gender Marker on a NYC Birth Certificate Affirmation/Affidavit for Providers

**APPLICANT**
The attached form may be used to change the gender marker on your birth certificate. While not required, it should help ensure that your documentation is complete.


**PROVIDER**
You may use the attached form to affirm/attest that a birth certificate’s gender marker should be changed. If you choose not use this form, you must still provide all the information requested.

1. When completing the form/letter, please be sure to provide a response for every blank line. Missing information may delay the application review process for your client.
2. If you are a physician, please fill out the form/letter and sign at the bottom.
3. If you are not a physician, you must have this form/letter notarized.
4. When you have completed the form/letter, please mail to:

   NYC Department of Health and Mental Hygiene
   Office of Vital Records, Corrections Unit, Attn: Nickolas Souleotis
   125 Worth Street, Room 144, CN-4
   New York, NY 10013

If you have additional questions, please email tgnyc@health.nyc.gov. You can also visit us online at www.nyc.gov/vitalrecords.
I, ____________________________, am a U.S.-licensed healthcare provider in good standing:

(Provider’s full name)

Please check one box:

☐ Physician (MD or DO)
☐ Doctoral-level psychologist (PhD or PsyD in clinical or counseling)*
☐ Social worker (LMSW or LCSW)*
☐ Physician assistant*
☐ Nurse practitioner*
☐ Marriage and family therapist*
☐ Mental health counselor*
☐ Midwife*

Note: Notarization of this letter is required for providers with an asterisk (*).

I am the healthcare provider of ____________________________, whom I have treated (or whose history I have reviewed and evaluated).

(Name of patient/client)

I hereby certify and confirm that, in keeping with contemporary expert standards regarding gender identity, ____________________________’s requested change of sex designation from _____ to _____ accurately reflects their gender identity.

(M/F)  (M/F)

(Name of patient/client)

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

Signature of Provider: ________________________________

Typed or Printed Name of Provider: ________________________________

Date: ________________________________

License Number: ________________________________  State Issued: ________________________________

License Type: ________________________________

NPI Number: ________________________________

Provide notary’s signature and legal information in box below:

July 28, 2017