



DEPARTMENT OF HEALTH AND MENTAL HYGIENE • OFFICE OF VITAL RECORDS

## 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.

You must also complete a **Correcting a Birth Certificate** application form (VR 172), available at:  
<http://www.nyc.gov/html/doh/html/services/vr-birth-correct.shtml>

### 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: Edna Timbers  
125 Worth Street, Room 144, CN-4  
New York, NY 10013

If you have additional questions, please email Edna Timbers ([etimmers@health.nyc.gov](mailto:etimmers@health.nyc.gov)). You can also visit us online at [www.nyc.gov/vitalrecords](http://www.nyc.gov/vitalrecords).

Provider's letterhead OR Provider's address: _____ Provider's phone: _____ Provider's email: _____	Patient's/Client's Full Name: _____ Patient's/Client's Date of Birth: _____ Patient's/Client's Address: _____
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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.  
 (Name of patient/client) (M/F) (M/F)

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:**