

AFFIDAVIT OF CHANGE OF GENDER

STATE OF IDAHO)
 : ss.
County of _____)

I _____, certify that my patient _____,
(name of licensed medical doctor) (full legal name of patient)

DOB _____, has undergone a change of gender from **female to male / male to female.**
(patient's birthdate) (circle one)

DATED this ___ day of _____, 2_____.

(signature of licensed medical doctor)

(printed name of licensed medical doctor)

SUBSCRIBED AND SWORN (or affirmed) before me this ___ day
of _____, 2_____.

(SEAL)

Notary Public for Idaho
Residing at:
My commission expires: