



**RI Department of Health Center for Vital Records Medical Professional Affidavit**

<b>Patient's Current Information</b>	Full Name:		
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not Yet Determined		Date of Birth:
<b>Licensee Information</b>	Full Name:		Title:
	Name and Address of Practice or Clinic:		<input type="checkbox"/> Licensed Physician (M.D. or D.O.) <input type="checkbox"/> Licensed Nurse Practitioner (N.P.) <input type="checkbox"/> Licensed Physician's Assistant (P.A)
	License # and State:	Telephone: (optional)	Email: (optional)
<b>Affidavit</b>	<p>I am in good standing in the State or jurisdiction listed above. I certify this patient has undergone appropriate treatment for the purpose of gender identity based on contemporary clinical standards. I make this affidavit in support of my patient's request for the sex field to be amended on the birth certificate registered with the Rhode Island Department of Health - Center for of Vital Records. In my medical opinion this patient identifies as:</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X</p> <p>_____</p> <p>Signature <span style="float:right">Date</span></p>		
<b>Notarization:</b>			
<p>On this _____ day of _____, 20____, before me, the undersigned notary public, personally appeared _____, who proved to me through satisfactory evidence of identification, which was _____, to be the person who signed the preceding document in my presence, and who swore or affirmed to me that the contents of this document are truthful and accurate to the best of their knowledge and belief.</p>			
<b>Affix Notary Stamp</b>		<b>Notary Signature</b> _____	
		<b>Notary ID #</b> _____ <b>Expiration Date</b> _____	

**Mailing Address:** Rhode Island Department of Health  
 Center for Vital Records  
 3 Capitol Hill, Room 101  
 Providence, RI 02908