MEDICAL AFFIDAVIT

In compliance with statute 333.2831(c) of the Michigan Compiled Laws, I certify that sex-reassignment surgery has been performed on the individual listed below.

Patient's Name (please print): _____
(Current Full Name)

Date of Birth: _____/_____/_____
Month Day Year

New Name (please print): _____
(New Name to be on Birth Certificate, if applicable)

I am the attending physician of the patient named above, with whom I have a doctor/patient relationship. The individual named above has had appropriate surgical procedures completed for gender transition to the new gender of ☐ female.
☐ male.

I declare that the foregoing is true and correct*.

Physician's Full Name (please print): _____

Medical License Number: _____ Issuing State: _____

Drug Enforcement Administration (DEA) Registration Number: _____

Specialty: ☐ Internist ☐ Endocrinologist ☐ Gynecologist
☐ Urologist ☐ Psychiatrist ☐ Other: _____

Mailing Address: _____

City/State/Zip: _____

Telephone Number: _____

Physician's Signature: _____ Date: _____

Notary Statement:

Signed and sworn before me on the _____ day of _____, in the year _____.

Notary in _____ County, State of _____.

My commission expires on _____.

_____ _____
Printed Name of Notary Signature of Notary

* Supplying false information to be used in the preparation of a vital record is prohibited by Michigan law (MCL 333.2894)

(Rev. 10-17)