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ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, State Bar number, and address):	*FOR COURT USE ONLY*
TELEPHONE NO.: FAX NO.(Optional): EMAIL ADDRESS (Optional): ATTORNEY FOR (Name):	
SUPERIOR COURT OF CALIFORNIA, COUNTY OF SAN DIEGO ☐ CENTRAL DIVISION, CENTRAL COURTHOUSE, 1100 UNION ST., SAN DIEGO, CA 92101 ☐ CENTRAL DIVISION, CIVIL, 330 W. BROADWAY, SAN DIEGO, CA 92101 ☐ NORTH COUNTY DIVISION, 325 S. MELROSE DR., VISTA, CA 92081	
PETITION OF:	
DECLARATION OF PHYSICIAN RE CHANGE OF GENDER	CASE NUMBER

I, _____, am a licensed physician in the state of _____. I attest that petitioner _____, whose medical record indicates a date of birth of _____, is a patient of mine for the purpose of gender transition. I attest the petitioner has undergone the clinically appropriate treatment for the purpose of gender transition to ☐ male ☐ female.

Physician's Medical License or Certificate Number: _____

Physician's Address: _____

_____

_____

_____

_____

Physician's Tel. No.: _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: _____ _____

Signature

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