STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

AFFIDAVIT OF HEALTH CARE PRACTITIONER
Gender Transition Evaluation

MUST BE COMPLETED BY A LICENSED PHYSICIAN, PHYSICIAN ASSISTANT, ADVANCE PRACTICE REGISTERED NURSE OR PSYCHOLOGIST

I _____, _____swear the following to be true:
NAME OF PRACTITIONER PERFORMING EVALUATION — TITLE (i.e., MD, PA, APRN, Psychologist)

My Practicing Address is _____,

in the City of _____, State of _____.

I hold a current license in good standing from the State of _____to

Practice as a _____. My license Number is _____.
PHYSICIAN, PHYSICIAN ASSISTANT, APRN, PSYCHOLOGIST — LICENSE#

I have evaluated _____,
BIRTH NAME

_____, _____, _____.
LEGAL NAME CHANGE, IF APPLICABLE — DATE OF BIRTH — CITY AND STATE OF BIRTH

and conclude the above-named individual has undergone surgical, hormonal, or other treatment clinically appropriate for gender transition, and that such individual's gender is _____.
MALE/FEMALE/NON-BINARY

_____ _____
SIGNATURE OF PRACTITIONER PERFORMING EVALUATION — DATE OF EVALUATION

Subscribed and sworn to me before this _____day of _____, 20_____

_____
NOTARY PUBLIC

(SEAL)

_____
EXPIRATION DATE

12-2023