# Request for Gender Designation Change

Return to Registration and Records
Library 1101
360.867.6180 | 360.867.6680 Fax

**STUDENT INFORMATION**

Student's Legal Name: _____
*Last* *First* *Middle*

Student ID: _____ Date of Birth: _____

Mailing Address: _____
*Street* *City* *State* *Zip*

Email: _____ Phone: _____

*I certify that the information on this form and the supporting documents are true and correct.*

Student's Signature: _____ Date: _____

**CERTIFICATION**

**Option 1. Court Decree**
Submit a copy of the court-approved decree changing gender along with this form to the Registration and Records Office.

**Option 2. Physician/Psychologist Approval**
The box below must be completed by a physician or psychologist/licensed therapist, who is licensed to practice in the United States, to determine that the gender change is being conducted with the World Professional Association for Transgender Health (WPATH) Standards of Care.

_____ *I hereby authorize my physician/psychologist/licensed therapist to release the information below to*
*Student's Initials* *The Evergreen State College for the purpose of updating my student record under my identified gender.*

**Practitioner's Full Name:** _____

☐ Physician ☐ Psychologist/Licensed Therapist

**Medical License or Certificate Number:** _____

**Examination Date:** _____ **Medical Case Number:** _____

**My professional opinion is that the applicant's:**

| **Birth sex was:** | **Current identification is:** |
|---|---|
| ☐ Female | ☐ Female |
| ☐ Male | ☐ Male |

*It has been determined this individual is sufficiently ready for, or has completed a gender transition, and it is intended that this change be permanent. This transition may or may not lead to surgical intervention. I certify under penalty of perjury that the information on this form is true and correct.*

Practitioner's Signature: _____ Date: _____