THE OHIO STATE UNIVERSITY

Office of Enrollment Services

University Registrar

registrar@osu.edu
614-292-9330 Phone

Declaration of Gender Designation Change

To be completed by applicant:	
Full Legal Name	Date of Birth
Permanent Address	Local Address (if different)
Telephone Number	Student ID Number
OSU Email (name.#)	

I certify under penalty of perjury that the information on this form is true and correct.

_____ _____
Applicant Signature Date

☐ I hereby authorize my physician/psychologist to release the information below to The Ohio State University for the purposes of updating my student record under my identified gender.

To be completed by a physician or a licensed psychologist/therapist, who is licensed to practice in the United States that the gender change is being conducted in accordance with World Professional Association for Transgender Health (WPATH) Standards of Care:		
	☐ Physician ☐ Psychologist/Licensed Therapist	
Full Name of Physician/Psychologist	Select One	
Medical License or Certificate Number	Issuing State	Telephone Number
Examination Date	Medical Case Number	
My professional opinion is that the applicant's:		
Birth Sex was: ☐ Male ☐ Female	Current Gender Identification is: ☐ Male ☐ Female	

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

_____ _____
Signature of Physician or Psychologist Date