PHYSICIAN'S STATEMENT OF GENDER CHANGE (PERSONAL MEDICAL RECORD)

State Form 56712 (5-19)
Indiana State Department of Health

INSTRUCTIONS:
1. *Complete form in blue or black ink or print form.*
2. *A licensed physician must complete either Section B or C (whichever is applicable) and D.*
3. *Applicant must complete Sections A and E.*
4. *Submit completed form with original signatures and a photocopy (front AND back) of your photo ID to the Indiana State Department of Health, Attn: Vital Records Division, 2 N. Meridian St., Indianapolis, IN, 46204.*

NOTE: Applicants born in the State of Indiana will receive an amended certificate of birth upon receipt of a fully competed State Form 49607 (Application for Search and Certified Copy of Birth Record) and the relevant fees. Applicants born outside the State of Indiana will be issued State Form 56713 (Confirmation of Receipt of Physician's Statement of Gender Change).

SECTION A – APPLICANT'S INFORMATION

Legal Name *(last, first, middle initial)*		Date of Birth *(mm/dd/yyyy)*
Address *(number and street)*	City	State
ZIP Code	State of Birth	

SECTION B – PHYSICIAN'S STATEMENT FOR GENDER CHANGE

I certify _____ has been under my care and has received appropriate clinical treatment for transition from:
(Applicant's name)

Check one:

☐ Male to Female ☐ Female to Male ☐ Male to X (non-binary) ☐ Female to X (non-binary)

SECTION C – PHYSICIAN'S STATEMENT FOR GENDER IDENTIFICATION FROM UNKNOWN

This Section is for use by a Physician to assign a gender to a patient with an "Unknown" or "U" designation on the patient's certificate of birth.

_____ had a gender designation of "unknown" at birth. I certify _____'s gender is now:
(Applicant's name) *(Applicant's name)*

Check one:

☐ Male to Female ☐ Female to Male

SECTION D – SIGNATURE OF PHYSICIAN

By signing this form, I swear or affirm under the penalty of perjury that the information on this form is true and correct.

Printed Name of Physician	Medical License Number	State of Issuance
Signature of Physician	Date Signed *(mm/dd/yyyy)*	Physician Telephone Number

SECTION E – SIGNATURE OF APPLICANT *(OR PARENT / GUARDIAN IF APPLICANT IS AN UNEMPANCIPATED MINOR)*

By signing this form, I authorize the above information to be released to the Indiana State Department of Health. I swear or affirm under the penalty of perjury that the information on this form is true and correct.

Printed Name of Applicant *(or Parent / Guardian if Applicant is an Unemancipated Minor)*	
Signature of Applicant *(or Parent / Guardian if Applicant is an Unemancipated Minor)*	Date Signed *(mm/dd/yyyy)*

**** FOR USE BY THE INDIANA STATE DEPARTMENT OF HEALTH ONLY. ****

The Indiana State Department of Health has reviewed the above application and affirmed the Physician is licensed and in good standing with the Indiana Professional Licensing Agency or the licensing agency of the issuing state.

Signed:_____ *(State Registrar, Director of Vital Records)* Date *(mm/dd/yyyy)*: _____