



OHIO DEPARTMENT OF PUBLIC SAFETY
BUREAU OF MOTOR VEHICLES

DECLARATION OF GENDER CHANGE

INSTRUCTIONS

The purpose of this form is to allow an individual, under the guidance and direction of a qualified and licensed medical professional, to change their gender designation. To be qualified, the medical professional must attest that the transition is being conducted in accordance with the guidelines set forth in the World Professional Association for Transgendered Health's (WPATH) Standard of Care. This change is only to be made as part of a permanent, full time gender transition.

If gender identification is marked as transitional, a new form must be submitted for each driver license / ID renewal until gender identification is complete. If the form is not submitted at renewal, the gender marker will revert back to the original gender.

Each individual is limited to changing their gender back to the original gender on their driver license or ID card one (1) time.

All records of the Ohio Department of Public Safety or Bureau of Motor Vehicles relating to the physical or mental condition of any person are confidential and are not open to public record.

Send completed form to:

Ohio Department of Public Safety
Bureau of Motor Vehicles
Attn: License Control
P.O. Box 16784
Columbus, Ohio 43216-6784

Phone: (614) 752-7500
Fax: (614) 752-7306

Please allow 7 - 10 days for processing. The applicant will be notified in writing if the gender change is approved, and will receive documentation that may be presented to any local License Bureau agency. The applicant must then surrender their current driver license as they receive their new, corrected card.



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TO BE COMPLETED BY APPLICANT (Please type or print in ink.)

APPLICANT'S LEGAL LAST NAME		FIRST NAME		MI
RESIDENTIAL ADDRESS		CITY	STATE	ZIP CODE
DRIVER LICENSE OR ID NUMBER	DATE OF BIRTH	TELEPHONE NUMBER () -		
I certify under penalty of perjury that the information on this form is true and correct.				
APPLICANT'S SIGNATURE X			DATE SIGNED	

RELEASE OF INFORMATION

I hereby authorize my physician / psychologist to release the information below to the Ohio Bureau of Motor Vehicles for the purposes of obtaining a driver license or an identification card under my identified gender. _____ (Applicant's Initials)

PHYSICIAN / PSYCHOLOGIST'S STATEMENT

To be completed by a physician or a licensed psychologist / therapist, who is licensed to practice in the United States that certifies that the gender change is being conducted in accordance with World Professional Association for Transgendered Health's (WPATH) Standard of Care.

- PHYSICIAN
 PSYCHOLOGIST / LICENSED THERAPIST

PHYSICIAN / PSYCHOLOGIST'S LAST NAME		FIRST NAME		TELEPHONE NUMBER () -
MEDICAL LICENSE / CERTIFICATE NUMBER	ISSUING STATE	NAME OF HOSPITAL OR MEDICAL CLINIC		
STREET ADDRESS	CITY	STATE	ZIP CODE	
EXAMINATION DATE	MEDICAL CASE NUMBER			
MY PROFESSIONAL OPINION IS THAT THE APPLICANT'S: BIRTH GENDER IS: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE GENDER IDENTIFICATION IS: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE GENDER CHANGE IS: <input type="checkbox"/> COMPLETE <input type="checkbox"/> TRANSITIONAL				
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 the penalty of perjury that the information on this form is true and correct.				
SIGNATURE OF PHYSICIAN / PSYCHOLOGIST X			DATE SIGNED	