www.dmvNow.com
Virginia Department of Motor Vehicles
Post Office Box 27412
Richmond, Virginia 23269-0001

GENDER DESIGNATION CHANGE REQUEST

Purpose: Use this form to request a change to the gender designation on a driver's license or identification card.

Instructions: Completed form must be signed by applicant and licensed provider and mailed to Medical Review Services at the above address.

Allow 5 business days for processing.
Incomplete or illegible forms cannot be processed.

APPLICANT INFORMATION/CERTIFICATION

FULL LEGAL NAME (last, first, mi, suffix) (print)	BIRTHDATE (mm/dd/yyyy)	DAYTIME TELEPHONE NUMBER ( )	VA CUSTOMER NUMBER/SSN	
STREET ADDRESS	CITY		STATE	ZIP CODE
MAILING ADDRESS (if different from above)	CITY		STATE	ZIP CODE

I request that the gender designation on my driver's license/identification card read as follows: (check one) ☐ MALE ☐ FEMALE

I certify that this request for gender designation is for the purpose of ensuring that my driver's license/identification card accurately reflects my gender identity and is not for any fraudulent or other unlawful purpose.

I further certify and affirm that all information I have presented in this form is true and correct, that any documents I have presented to DMV are genuine, and that the information included in all supporting documentation is true and accurate. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal violation.

APPLICANT SIGNATURE	DATE (mm/dd/yyyy)

LICENSED PROVIDER CERTIFICATION

PROVIDER NAME (print)

I AM LICENSED AS A: (check one)

☐ PHYSICIAN ☐ NURSE PRACTITIONER ☐ PSYCHOLOGIST
☐ PSYCHIATRIST ☐ CLINICAL SOCIAL WORKER ☐ PROFESSIONAL COUNSELOR

LICENSE NUMBER (required)	STATE ISSUING LICENSE (required)	LICENSE EXPIRATION DATE (mm/dd/yyyy)(required)

PROVIDER ADDRESS			TELEPHONE NUMBER ( )
CITY	STATE	ZIP CODE	FAX NUMBER ( )

In my professional opinion, the applicant's gender identity is (check one): ☐ MALE ☐ FEMALE

I certify that my practice includes the treatment and counseling of persons with gender identity issues, including the applicant named above who is my patient.

I further certify and affirm that, to the best of my knowledge and belief, all information I have presented in this form is true and correct, that any documents I have presented to DMV are genuine, and that the information included in all supporting documentation is true and accurate. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal violation.

PROVIDER SIGNATURE	DATE (mm/dd/yyyy)