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

SEX DESIGNATION CHANGE REQUEST

Purpose: Use this form to request a change to the sex 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 sex designation on my driver's license/identification card read as follows: (check one) ☐ MALE ☐ FEMALE

I certify that this request for sex designation is for the purpose of ensuring that my driver's license/identification card accurately reflects my sex 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)

PARENT CERTIFICATION (if applicant is under age 18)

☐ Parent/Legal Guardian, check the box if you give consent for this minor to change the sex identity listed with Department of Motor Vehicles (DMV) and to display this information on his/her identification card or driver's license.

PARENT / GUARDIAN NAME (print)	PARENT / GUARDIAN SIGNATURE	DATE (mm/dd/yyyy)

COURT ORDER OR LICENSED PROVIDER CERTIFICATION

Check the applicable box:

☐ Sex designation change request is based on a court order. Submit a copy of the court order with the completed DL 17. The Licensed Provider Information below does not need to be completed.

☐ Sex designation change request is based on the certification of a licensed provider. A licensed provider is required to complete the section below.

Licensed Provider Information

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 sex identity is (check one): ☐ MALE ☐ FEMALE

I certify that my practice includes the treatment and counseling of persons with sex 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)