Reset Form

PHYSICIAN'S STATEMENT OF GENDER CHANGE

State Form 55617 (R2 / 11-24)
INDIANA BUREAU OF MOTOR VEHICLES

BUREAU OF MOTOR VEHICLES
100 North Senate Avenue
Room N481
Indianapolis, IN 46204

The legal authority of this form is IC 9-24-9-2 and 140 IAC 7-1.1-3.

INSTRUCTIONS: *1. Complete form in blue or black ink or print form.*
2. A licensed physician must complete Section 2.
3. Applicant must complete Section 3.
4. Submit completed form with original signatures to any BMV license branch location.

SECTION 1 - APPLICANT'S INFORMATION			
Legal Name (*last, first, middle initial*)	Indiana Driver's License Number (DLN)	Date of Birth (*mm/dd/yyyy*)	
Address (*number and street*)	City	State	ZIP code

SECTION 2 - PHYSICIAN'S STATEMENT FOR GENDER CHANGE (140 IAC 7-1.1-3(d)(3)(C)(ii))

I certify _____ successfully underwent all treatment necessary to permanently change
(Insert applicant's name.)

_____ gender from _____ to _____.
(Insert applicant's name.) *(Insert prior gender.)* *(Insert new gender.)*

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 3 – SIGNATURE OF APPLICANT

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

Printed Name of Applicant	
Signature of Applicant	Date Signed (*mm/dd/yyyy*)