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 professional, to change their gender designation.

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: (844) 644-6268
Email: GenderChange@dps.ohio.gov
Fax: (614) 351-6019

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.

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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 ( ) -	MY GENDER IDENTITY IS ☐ MALE ☐ FEMALE	

I certify that this request for gender designation is for the purposes of ensuring my driver's license/identification card accurately reflects my gender identity and is not for any fraudulent or other unlawful purpose. I certify under penalty of perjury that all information on this form is true and correct.

APPLICANT'S SIGNATURE	DATE SIGNED
X	

RELEASE OF INFORMATION

I hereby authorize my licensed professional 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)

LICENSED PROFESSIONAL'S STATEMENT

To be completed by a physician, psychologist, therapist, nurse practitioner, or social worker who is licensed to practice in the United States that certifies the gender identity of the applicant.

☐ PHYSICIAN ☐ NURSE PRACTITIONER ☐ PSYCHOLOGIST ☐ THERAPIST ☐ SOCIAL WORKER

LICENSED PROFESSIONAL'S LAST NAME	FIRST NAME	TELEPHONE NUMBER ( ) -	
PROFESSIONAL LICENSE / CERTIFICATE NUMBER	ISSUING STATE	NAME OF HOSPITAL OR MEDICAL CLINIC	
STREET ADDRESS	CITY	STATE	ZIP CODE

MY PROFESSIONAL OPINION IS THAT THE APPLICANT'S GENDER IDENTITY IS ☐ MALE ☐ FEMALE

I certify that my practice includes the treatment and counseling of persons with gender identity concerns, including the applicant named above, who is my patient. I certify under the penalty of perjury that all information on this form is true and correct.

SIGNATURE OF LICENSED PROFESSIONAL	DATE SIGNED
X	