|  |  |  |  |
| --- | --- | --- | --- |
| **New Jersey Department of Health**  **Office of Vital Statistics and Registry** P. O. Box 370Trenton, NJ 08625-0370 | | **CERTIFICATE OF SEX REASSIGNMENT**  **VIA SURGICAL PROCEDURE** | |
| *In compliance with N.J.S.A. 26:8-40.12, the State registrar shall issue an amended certificate of birth to a person born in this State who undergoes sex reassignment surgery and requests an amended certificate of birth which shows the sex and name of the person as it has been changed. The State registrar shall issue the amended certificate of birth upon receipt of (1) a certified copy of an order from a court of competent jurisdiction which indicates the name of the person has been changed and (2) a medical certificate from the person’s licensed physician which indicates the sex of the person has been changed by surgical procedure.* | | | |
| Name of Patient (Current Full Name) *(Print)* | | | Date of Birth *(Month/Day/Year)* |
| New Name to be on Birth Certificate (if applicable) *(Print)* | | | |
| The individual named above has undergone surgical  procedure(s) that have caused the individual’s gender to be changed to:  Female  Male  Explain: | | | |
| Date: | | | |
| Full Name of Physician *(Print)* | | | Telephone Number |
| Medical License Number | Issuing State | | DEA Registration Number |
| Medical Specialty | | | |
| Mailing Address | | | |
| City, State, Zip Code | | | |
| *I am the attending physician of the patient named above, with whom I have a doctor/patient relationship, and have performed the above listed surgical procedure(s) on the patient. I declare that the foregoing is true and correct.* | | | |
| Signature of Physician | | | Date |