

STATE OF ALASKA
DIVISION OF MOTOR VEHICLES

CERTIFICATION FOR CHANGE OF SEX DESIGNATOR ON DRIVER LICENSE OR IDENTIFICATION CARD

This certification must be accompanied by one of the following:

- Application for a Alaska Driver License, Permit or Identification Card (Form 478)
- Commercial Driver Medical and Self Certifying Verification (Form 413) (if applicable)

If one of the following documents can be provided section B and C of this form are not required.

- Amended Birth Certificate
- Valid US Passport
- Court Order issued by a court in the United States granting change of sex or gender

THIS FORM MUST BE COMPLETED IN FULL AND MUST BE COMPLETED IN BLACK OR BLUE INK.

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| A APPLICANT INFORMATION AND SEX DESIGNATION STATEMENT | | | |
| FULL LEGAL NAME: | First _____ | Middle _____ | Last _____ Suffix _____ |
| ALASKA DL or ID number _____ | Date of Birth _____ | I wish the sex designation on my Driver License/ID Card to read: <input type="checkbox"/> Male <input type="checkbox"/> Female _____ Signature | |
| B PATIENT MEDICAL RELEASE AUTHORIZATION | | | |
| I _____, authorize the licensed provider listed in section C to release information related to this request. I hereby certify under penalty of unsworn falsification that this request for the selected sex designation to appear on my driver's license/ID Card accurately reflects my gender identity and is not for any fraudulent or other unlawful purpose. | | | |
| X _____ Signature | | _____ Date | |
| C LICENSED PROVIDER CERTIFICATION This section must be completed in full by a licensed physician in medicine or osteopathy, social worker, psychologist, professional counselor, physician assistant or advanced nurse practitioner. | | | |
| Patient Name _____ | | Provider Full Name _____ | |
| Provider Address _____ | | Telephone Number _____ | |
| Professional License Number _____ | | License-Issuing Jurisdiction _____ | |
| I am a licensed <input type="checkbox"/> physician in medicine or osteopathy <input type="checkbox"/> social worker <input type="checkbox"/> psychologist <input type="checkbox"/> professional counselor <input type="checkbox"/> physician assistant <input type="checkbox"/> advanced nurse practitioner | | | |
| I hereby certify under penalty of unsworn falsification that I am a licensed provider in the field checked above. I have treated the applicant or reviewed and evaluated the medical history of the applicant with regard to the condition necessitating the requested change of sex designator on the driver license or ID card. The applicant has had appropriate clinical treatment for the condition necessitating the change and the change is expected to be permanent. The applicant's gender identification is <input type="checkbox"/> Male <input type="checkbox"/> Female. | | | |
| X _____ Provider Signature | | X _____ Provider Printed Name and Title Date | |
| THE PROVIDER SIGNATURE MUST BE ORIGINAL AND MAY NOT BE STAMPED OR IN AN ELECTRONIC FORMAT. | | | |
| DMV Use Only | <ul style="list-style-type: none"> • Amended Birth Certificate • Valid US Passport • US Court Order | | |
| | Jurisdiction: _____ | Number : _____ | Jurisdiction: _____ |

For questions or information on changing the sex designator on a license please contact:

Anchorage Driver Licensing
3901 Old Seward Hwy, Ste 101
Anchorage, Alaska 99503
(907) 269-5551 Phone

(907) 269-3774 Fax