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MEDICAL CERTIFICATION AND AUTHORIZATION
(GENDER CHANGE)
NAC 483.070

PLEASE NOTE: The Department of Motor Vehicles MUST receive this report within 30 DAYS after the date of the examination.

Driver License Number _____ Date of Birth (MM/DD/YYYY) _____
Patient's Name _____
Last First Middle
Mailing Address _____
Residence Address _____
Daytime Telephone Number _____

Section 2 - Certification:

I certify (or declare) under penalty or perjury under the laws of the State of Nevada that the foregoing is true and correct.

Applicant's Signature _____ Date _____

AUTHORIZATION

All records of the department relating to the physical or mental condition of any person are confidential and not open to public inspection.

I hereby authorize my physician, to release the information below to the Nevada Department of Motor Vehicles for the purposes of obtaining a driver license or an identification card under my identified gender.

Patient's Signature _____ Date _____

Section 3 - TO BE COMPLETED BY A PHYSICIAN LICENSED IN THE UNITED STATES

My professional opinion is that the applicant is:

Living full-time as identified gender and undergoing treatment as: ___ Male ___ Female
OR
Gender identification is: ___ Male ___ Female

Section 4 - TO BE COMPLETED BY A PHYSICIAN LICENSED IN THE UNITED STATES

E-mail Address _____ Examination Date _____ Medical Case Number _____

Medical License or Certification number _____ Issuing State _____ License Number _____

Name of Hospital or Medical Clinic _____

Mailing Address _____ City _____ State _____ Zip Code _____

Physical Address (if different from mailing address) _____ City _____ State _____ Zip code _____

Full Name of Physician (PLEASE PRINT) _____

Signature of Physician _____