DATE

To Whom It May Concern:

This letter contains my strong endorsement for [LEGAL FIRST LASTNAME], also known as [CHOSEN FIRST LASTNAME], [DOB] decision to undergo gender-affirming [MASCULINZING CHEST or BREAST SURGERY].

I am a \*\*\*[LICENSED MENTAL HEALTH PROVIDER] [LICSW/LMHC/LASW/LMFT/PSYCHIATRIST/PSYCHOLOGIST/PSYCHIATRIC ARNP/PMHNP-BS ] and have been seeing [CHOSEN NAME] [FREQUENCY OF VISITS] since [MONTH YEAR] after [CHOSEN NAME] and [PRONOUNS] parents sought my services to help [CHOSEN NAME] cope with Gender Dysphoria. I have experience and knowledge of gender-diverse identities and expressions which includes assessing and treating gender dysphoria in adolescents.

**ASSOCIATE LEVEL MENTAL HEALTH PROVIDERS MAY AUTHOR LETTER AND INCLUDE SIGNATURE AND ADDENDUMN FROM SUPERVISOR EMBEDDED IN THE ASSOCIATE LEVEL PROVIDER’S LETTER SIGNATURES SHOULD BE ON THE SAME PAGE**

During a comprehensive psychosocial assessment, I learned that [CHOSEN NAME] has had consistent and persistent gender dysphoria since [AGE], yet did not have the language to understand [PRONOUNS as transgender until [PRONOUNS] was about [XX] years old. [CHOSEN NAME] came out to [PRONOUNS] parents and community and made a social gender transition [AGE OR LIFE EVENT]. [PRONOUNS] symptoms do meet DSM-5 criteria for a Gender Dysphoria diagnosis, and [PRONOUNS] has been living in [AFFIRMED GENDER IDENTITY] for [X] [MONTHS/YEARS].

[CHOSEN NAME] has been evaluated for coexisting mental health diagnoses and **{*choose which applies*}** Does not present with any mental health conditions outside of Gender Dysphoria. **OR** Presents with [COEXISTING MENTAL HEALTH DIAGNOSES] which is/are adequately managed.} [CHOSEN NAME] is emotionally stable and is intellectually able to make an informed decision to undergo [SURGERY TYPE]. Although [PRONOUNS] is not yet 18, I strongly recommend [SURGERY TYPE] to alleviate [CHOSEN NAME]’s Gender Dysphoria.

*Optional if appropriate*: {Since [CHOSEN NAME] has chosen not to pursue hormone therapy at this time, [SURGERY TYPE] is even more important to increasing [PRONOUNS] safety and ability to pass as [PRONOUNS] affirmed gender.}

Studies conducted throughout the world conclude that surgery is an extremely effective treatment for Gender Dysphoria. According the WPATH Standards of Care Version 7.0, “refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization.” The WPATH endorses chest surgery for patients under 18 if they are suffering from Gender Dysphoria and have full parental consent to undergo treatment. [CHOSEN NAME]’s parents/guardians enthusiastically support this surgery because they know it will greatly alleviate their child’s suffering.

I am available for consultation and coordination of care and welcome phone calls to establish this upon a release of information from my client.

Sincerely,

[WET SIGNATURE]

PROVIDER NAME, CREDENTIALS

PROVIDER CONTACT INFO

**SUPERVISOR ADDENDUM**

I am the supervisor of [CHOSEN NAME]’s therapist [ASSOCIATE LEVEL THERAPIST NAME]. I agree with the assessment and diagnosis of gender dysphoria.

Sincerely,

[WET SIGNATURE]

SUPERVISOR NAME

CONTACT INFO