COLORADO
Center for Health & Environmental Data
Department of Public Health & Environment

SEX DESIGNATION FORM

CLEAR FORM

INSTRUCTIONS: This form must be completed and submitted along with the "Form to Correct or Change a Colorado Birth Certificate" in order to request a change to the sex currently listed on the birth certificate.

1. If registrant is **18 YEARS OLD OR OLDER** complete section A.
2. If registrant is **UNDER 18 YEARS OLD** a Medical or Health Care provider must complete section B.

Note: Any further amendment to the sex designation on a birth certificate requires a court order pursuant to section 5.5(C)(1).

SECTION A - ADULT REGISTRANT

In accordance with the Colorado Board of Health regulation 5 CCR 1006-1 Section 5.5(C)(2)(a) and C.R.S. 25-2-113.8

I would like to change the sex listed on my birth certificate to: (Check Box) ☐ Male ☐ Female ☐ X

PRINT REGISTRANT'S NAME			Date of Birth	
Address		City	State	Zip Code
Phone	Email		*SSN#	

*(requested in accordance with HB19-1039)

REGISTRANT'S SIGNATURE

SIGNATURE _____ DATE _____

SECTION B - MEDICAL OR HEALTH CARE PROVIDER for REGISTRANT UNDER 18

I am a medical or behavioral health provider licensed in good standing to practice medicine. I am a health care provider for: _____ (Patient's Name) _____ (*SSN#)

*(requested in accordance with HB19-1039)

who was born a _____ (Sex) on _____ (Patient's Date of birth) in Colorado.

I attest the person listed above in my professional opinion does not accurately reflect their gender identity and their sex designation should be changed accordingly. (5 CCR 1006-1 Section 5.5(C)(2)(b)) and C.R.S. 25-2-113.8

The sex listed on the birth certificate should reflect: (Check Box) ☐ Male ☐ Female ☐ X

I hereby swear, under the penalty of perjury, that the foregoing declaration is true and correct to the best of my knowledge.

Signature of Medical or Behavioral Health Provider	Print Name		Date
Medical License or Certificate License #	State/Country where license is issued (If outside of Colorado submit a copy of your active license)		
Provider's Organizational Name (if applicable)			
Address	City	State	Zip code
Phone	Email		