Nebraska Department of Motor Vehicles

Certification of Sex Reassignment

____
Applicant's Name

______________________________________ ______________________
Applicant's Driver License Number *Applicant's Date of Birth*

I certify that the above named applicant has undergone the necessary sex reassignment procedures required for social gender recognition and is requesting that a driver license/ID card be issued using

_____male_____female as the gender.
Select One

____ ______________________
*Certifying Medical Professional's Printed Name** *Date*

____ ______________________
Medical Professional's Address *Phone Number*

____
Medical Professional's Signature

* This form must be completed by one of the following: doctors of medicine, doctors of osteopathy, physician assistants, advanced practice nurses or doctors of chiropractic.

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