

Name:	Legal Name²:
Address:	City State & ZIP:
Phone:	Email:
Birth Date:	SSN:
Height¹:	Weight¹:
HIV Status: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unknown	Smoker¹: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> I want to plan a pre-operative consultation prior to my surgery date	<input type="checkbox"/> I have concerns about vaginal depth and may require a skin graft (MTF)

- Criteria for surgery: weight less than 210 lbs and non-smoker, due to increased risk of healing related complications associated with smoking. If you can not meet this criteria, consider postponing your surgery until you can – your recovery will be much easier. Contact Dr. Bowers if your date is getting close and you have not been able to quit smoking or lose weight. If you show up in Trinidad not ready, your surgery will be postponed.
- Legal name required only for Surgical Declaration Letter, which is used to certify permanent and irrevocable SRS/GRS for passport, birth certificate and legal ID where required. The letter will indicate NEW NAME aka LEGAL NAME if appropriate.

Date Hormone Therapy Started: _____

Endocrinologist or Physician: _____ **Name:** _____
 (if applicable) _____ **Contact:** _____

Real Life Test Started: _____

Recent Employment History: _____
 (optional) _____

Primary Relationship(s): (optional) _____

In Case of Emergency: _____ **Name:** _____
 (required) _____ **Contact:** _____

Letter of Recommendation #1: _____ **Name:** _____
 (if known, note that 2 letters are required) _____ **Contact:** _____

Letter of Recommendation #2: _____ **Name:** _____
 (if known, note that 2 letters are required) _____ **Contact:** _____

Do you have a target date or timeframe for your surgery? _____

Which surgery or surgeries are you applying for? _____

If you expect to file a claim with your insurance company, please list company name and contact information. _____

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| <ul style="list-style-type: none"> Dr. Bowers and Mt. San Rafael Hospital require candidates to meet the requirements set by the WPATH Standards of Care. Relationship Information is optional but will help us to be sensitive to your living situation and significant relationship(s). We understand that you may not have arranged for Letters of Recommendation at the time this application is made. If you know the professionals who you expect to refer you, identifying them will permit us to contact them if we do not receive these prior to your surgery. If filing a claim with your insurance company, signing below gives permission to Dr. Bowers' office to communicate with your insurance company regarding the claim. | <p>Please enclose</p> <p><input type="checkbox"/> \$500 (Personal Check Acceptable) down-payment to reserve a date (non-refundable)</p> <p><input type="checkbox"/> A photograph (so that we can identify you when you show up for your surgery)</p> <p><input type="checkbox"/> HIV Status (performed within 12 weeks of surgery)</p> <p>Photo Release</p> <p>Dr. Bowers may take photos at the time of surgery for education, website, seminars. I give permission for Dr. Bowers to anonymously photograph my surgery</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
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Signature: _____ **Date:** _____