WASHINGTON INTERSCHOLASTIC ACTIVITIES ASSOCIATION

PRE-PARTICIPATION BIOLOGICAL SEX ATTESTATION

Student Name: _____ Date of Birth: _____

MEDICAL PROVIDER VERIFICATION

I am a licensed health care provider. Based upon my professional medical assessment and our records for the named student, I attest that the student's biological sex is: ☐ **MALE** ☐ **FEMALE**

MEDICAL PROVIDER ATTESTATION

I certify that I have reviewed the relevant medical information and/or findings necessary to make this determination and that the biological sex designation selected in the Medical Provider Verification represents my professional medical attestation.

I understand that this statement is being provided for purposes of student eligibility and participation in interscholastic athletic activities governed by applicable Washington State requirements

I attest that the information provided on this form is accurate to the best of my professional knowledge.

MEDICAL PROVIDER INFORMATION

Name of Health Care Professional (Print): _____Date: _____

Address: _____Phone: _____

Signature of Health Care Provider: _____, MD, DO, ARNP, PA, ND

**This form should be retained and kept on file at the student's school.*