



Application for Recognition Certificate for a Child

Important Notice - Information provided in the application will be treated
CONFIDENTIALLY

Personal details of the child the application relates to

Full Name of child: _____

Address of child: _____

Date of Birth: _____

Place of Birth: _____

Full Names of
Child's Parents: _____

Personal details of the person making the application (Applicant)

Full Name of Applicant/s: _____

Address of Applicant/s: _____

Relationship of Applicant/s
to the child: _____

Reassignment Procedure

The child this application relates to has undergone a reassignment procedure from:

- (a) Male to Female
- (b) Female to Male

*Tick the appropriate box and **attach** a statement signed by a medical practitioner that the person has undergone the reassignment procedure.*



Government of **Western Australia**
 Department of **Justice**
 Gender Reassignment Board

Compliance with Section 15 of the *Gender Reassignment Act 2000*

The reassignment procedure was carried out in this State.

The child's birth was registered in the State.

The child is a resident of this State and has been a resident of this State for not less than 12 months.

*Tick the appropriate box or boxes and **attach** a certified copy of the child's birth certificate and any other relevant documents such as-*

- (i) documents relating to where the reassignment procedure was carried out;*
- (ii) the original, or certified copies, of any documents showing proof of residency and length of residency.*

These are the reasons that I believe that it is in the best interests of the child that a recognition certificate is issued in respect of the child.

*You may wish to **attach** any information you consider relevant.*

The child is married

The child is not married

Tick the appropriate box

A recognition certificate cannot be issued to a person who is married.



Government of **Western Australia**
Department of **Justice**

Gender Reassignment Board

Hearing of application

I wish to, or the child wishes to, attend the hearing of this application. []

I do not wish to, or the child does not wish to, attend the hearing of this application. []

I wish to, or the child wishes to, appear at the hearing of this application and to make submissions to the Board. []

Tick the appropriate box

Declaration by applicant

I declare that to the best of my knowledge no statement made in this application is false, or misleading in any material respect.

Signature: _____

Date: _____

Name of person signing: _____

Note:

Section 23 of the *Gender Reassignment Act 2000* provides that it is an offence for a person to make a statement knowing it to be false or misleading in a material respect for the purpose of, or in connection with, an application.

Penalty: \$2000 or imprisonment for 6 months.

Note:

1. Please supply a phone number and email address for the Board to contact you on.
2. An application fee of \$40 applies. Please complete and attach the Board's Credit Card Authorisation form for payment along with this completed application form and supporting documentation to:

Postal Address:

Executive Officer
Gender Reassignment Board of W.A.
PO Box U1991
PERTH WA 6845

Address:

Executive Officer
Gender Reassignment Board of W.A.
6th Floor
565 Hay Street
PERTH WA 6000

Email Address: Executive Officer, Gender Reassignment Board of W.A.
sat@justice.wa.gov.au