

## FAA GENDER DYSPHORIA MENTAL HEALTH STATUS REPORT

(Updated 06/24/2020)

Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Applicant ID# \_\_\_\_\_ PI# \_\_\_\_\_

The following information must be addressed in the treating provider's evaluation. Evaluation should be performed in accordance with a comprehensive mental health assessment following the [World Professional Association for Transgender Health \(WPATH\) guidelines](#) (Note: Link must be opened in Google Chrome.)  
 Submit either this status report sheet\* or supporting documentation addressing each item to your AME or to the FAA at:

Federal Aviation Administration  
 Civil Aerospace Medical Institute, Bldg. 13  
 Aerospace Medical Certification Division, AAM-300  
 PO Box 25082  
 Oklahoma City, OK 73125-9867

1. I am a board certified psychiatrist or licensed psychologist AND I meet the criteria for a qualified mental health professional" per WPATH (current version) guidelines.  Yes  No-explain
  
2. This airman meets the DSM-5 diagnostic criteria for Gender Dysphoria and the condition is not secondary to, or better accounted for, by other diagnoses.  Yes  No-explain
  
3. PSYCHIATRIC HISTORY:
 

Current mental health diagnosis or coexisting mental health concerns.....	<input type="checkbox"/> None <input type="checkbox"/> Yes-explain
Previous mental health diagnosis or coexisting mental health concerns.....	<input type="checkbox"/> None <input type="checkbox"/> Yes-explain
ER visit or hospitalization for any psychiatric illness or condition ever.....	<input type="checkbox"/> None <input type="checkbox"/> Yes-explain
Any suicide attempt(s) ever.....	<input type="checkbox"/> None <input type="checkbox"/> Yes-explain
Substance Use disorder per DSM-5..... (e.g. alcohol, cannabis, stimulants, hallucinogens, opioids)	<input type="checkbox"/> None <input type="checkbox"/> Yes-explain
  
4. PSYCHIATRIC TREATMENT: (List start and end dates on each. For medications, also note name, dose, and side effects, if any.)
 

Current use.....	<input type="checkbox"/> None <input type="checkbox"/> Yes-explain
Previous use.....	<input type="checkbox"/> None <input type="checkbox"/> Yes-explain
Psychotherapy for any condition other than GD (e.g., depression, anxiety) .....	<input type="checkbox"/> None <input type="checkbox"/> Yes-explain
Other treatments (e.g., cognitive therapy, talk therapy, electroconvulsive therapy)	<input type="checkbox"/> None <input type="checkbox"/> Yes-explain
  
5. CURRENT STATUS: Airman is doing well. There are no mental health concerns. Psychotherapy (if any) is for gender dysphoria only. No other treatment is needed (do not include support group or support group counseling).  Yes  No-explain
  
6. Any evidence of cognitive dysfunction or is a formal neuropsychological evaluation indicated?  None  Yes-explain
  
7. Do you have ANY concerns regarding this airman?  None  Yes-explain

\_\_\_\_\_  
 Treating Provider Signature

\_\_\_\_\_  
 Date of Evaluation

\_\_\_\_\_  
 Name or Office Stamp

\_\_\_\_\_  
 Phone Number

**\*For any response which requires further explanation, submit supporting documentation. In some cases, actual records will be required.**