UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
EVANSVILLE DIVISION

J.A.W.,	)	
	)	
Plaintiff,	)	
	)	
v.	)	
	)	Cause No. 3:18-cv-37-WTL-MPB
EVANSVILLE VANDERBURGH SCHOOL CORPORATION,	)	
	)	
	)	
Defendant.	)	

INTRODUCTION TO APPENDIX AND REQUEST TO TAKE JUDICIAL NOTICE

In support of its Response in Opposition to Plaintiff's Motion for Preliminary Injunction, the Evansville Vanderburgh School Corporation ("EVSC") hereby submits this Appendix of materials and requests that the Court take judicial notice of the same.

Pursuant to Federal Rule of Evidence 201, the Court "must take judicial notice if a party requests it and the court is supplied with the necessary information." "It is well settled that courts may take judicial notice of common knowledge and matters of public record not subject to reasonable dispute." *United States v. Hemphill*, 447 Fed. Appx. 733, 736 (7th Cir. 2011). Each of the materials contained in this Appendix falls within the category of facts of which the Court may take judicial notice. *Schmude v. Sheahan*, 312 F. Supp. 2d 1047, 1064 (7th Cir. 2004) ("it is routine for courts to take judicial notice of both newspaper articles and court records, among other things."); *Jutzi-Johnson v. United States*, 263 F.3d 753, 757 (7th Cir. 2001) (statistical surveys and studies); *Driebel v. City of Milwaukee*, 298 F.3d 622, 630 n.2 (7th Cir. 2002) (official rules and regulations); *Hemphill*, 447 Fed. Appx. at 736 (7th Cir. 2011) (statutes and

ordinances). Thus, it is proper for the Court to take judicial notice of the materials contained in the Appendix.

WHEREFORE, EVSC requests that the Court take judicial notice of the materials contained in this Appendix.

Respectfully submitted,

s/ Patrick A. Shoulders
Patrick A. Shoulders #308-82
Robert L. Burkart #16664-82
Jean M. Blanton #24840-82
ZIEMER STAYMAN WEITZEL & SHOULDERS, LLP
20 N. W. First Street
P. O. Box 916
Evansville, IN 47706
Tel. No. (812) 424-7575
Fax No. (812) 421-5089
Email: pshoulders@zsws.com
rburkart@zsws.com
jblanton@zsws.com

Attorneys for the Defendant.

CERTIFICATE OF SERVICE

I certify that on the 3rd day of July, 2018, a copy of the foregoing document was filed electronically. Notice of this filing will be sent to the following parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

Kenneth J. Falk
kfalk@aclu-in.org

Gavin M. Rose
grose@aclu-in.org

Jan P. Mensz
jmensz@aclu-in.org

s/ Patrick A. Shoulders
Patrick A. Shoulders

APPENDIX

TABLE OF CONTENTS

In re Change of Birth Certificate

Court of Appeals of Indiana

December 4, 2014, Decided; December 4, 2014, Filed

No. 79A03-1403-MI-91

Reporter
22 N.E.3d 707 *; 2014 Ind. App. LEXIS 589 **

IN RE PETITION FOR CHANGE OF BIRTH CERTIFICATE

Prior History: [1]** APPEAL FROM THE TIPPECANOE CIRCUIT COURT. The Honorable Donald L. Daniel, Judge. Cause No. 79C01-1303-MI-33.

Counsel: FOR APPELLANT: JON LARAMORE, HARMONY A. MAPPES, Faegre Baker Daniels LLP, Indianapolis, Indiana.

Judges: FRIEDLANDER, Judge. VAIDIK, C.J., and MAY, J., concur.

Opinion by: FRIEDLANDER

Opinion

[*707] OPINION - FOR PUBLICATION

FRIEDLANDER, Judge

Appellant is a transgender male who identifies as a man, lives as a man, and has undergone extensive medical treatment for gender transition, including gender reassignment surgery. Appellant filed a petition to change his legal gender so that he could correct the gender markers on his birth certificate. The trial court denied the petition based upon a perceived lack of authority to grant such a request. In this uncontested appeal, Appellant contends that the trial court erred by refusing to grant the petition.

We reverse and remand.

In 1988, Appellant was born in Indiana as a genotypical female. Since 2008, Appellant has received ongoing psychotherapy to address longstanding gender dysphoria **[*708]** (formerly known as gender identity disorder). As Appellant's desire and readiness to pursue gender reassignment became clear, Appellant began living as a male in January 2011 and shortly thereafter **[**2]** started testosterone treatment, which he has since continued. Appellant legally changed his name in 2012, and he completed sex reassignment surgery the following year. According to his surgeon, Appellant's true gender, based upon psychological and medical testing, is male. Appellant has changed his name and gender mark on his driver's license, as well as with the Social Security Administration. His birth certificate is the only significant life document that remains to be changed.

On March 26, 2013, Appellant filed a petition for change of gender in Tippecanoe Circuit Court. The petition sought an order changing Appellant's legal gender from female to male "for the purposes of meeting the requirements of the Indiana State Department of Health for changing the gender designation on birth records." *Appendix* at 6. Appellant stated in the petition that he had successfully transitioned to a male role in society, in accordance with accepted medical standards of care for gender dysphoria, and that he desired to change his gender designation so that his birth record "may be more congruent with his appearance and social role." *Id*.

Appellant appeared pro se at the uncontested hearing on the petition **[**3]** on February 12, 2014. He presented evidence from his surgeon, therapist, and endocrinologist detailing his gender transition. He also provided the court with a letter from the Indiana State Department of Health (the ISDH) setting out its official process for changing the gender marker on birth records. In the letter, the ISDH Birth Record Amendment Supervisor stated in relevant part:

> The [ISDH] Registrar's manual states that we need a court order to change the gender on a birth record for a person who has gone through Gender Reassignment Surgery.
>
> The court order needs to tell us the person's name, date and place of birth and needs to tell us to change the original gender of the person on the

EXHIBIT A

> person's birth certificate.
> The [ISDH] Vital Records office will accept any court ordered gender change from any valid court in the United States.

Id. at 9. The court took the matter under advisement after specifically finding that the petition had been made in good faith and not for a fraudulent or unlawful purpose.

On February 14, 2014, the trial court issued an order denying the petition. The court concluded that it did not have authority to grant such a request, noting that the Indiana General Assembly had not yet spoken on the issue. On appeal, **[**4]** Appellant contends that the trial court had authority pursuant to *Ind. Code Ann. § 16-37-2-10* (West, Westlaw current with all 2014 Public Laws of the 2014 2nd Regular Session & 2nd Regular Technical Session of the 118th General Assembly), as well as the court's inherent equitable authority.

I.C. § 16-37-2-10(b) provides in relevant part: "The state department may make additions to or corrections in a certificate of birth on receipt of adequate documentary evidence". Like name changes,[1] the ISDH defers to the courts by requiring a court order to establish adequate documentary evidence for an amendment **[*709]** of gender on a birth certificate. Courts in our state have entered such orders. *See In re Davis, 1 N.E.3d 184 (Ind. Ct. App. 2013)* (observing that trial court granted petition to change gender on ***birth certificate***). Further, the Indiana Bureau of Motor Vehicles expressly recognizes "certified ***amended birth certificate***[s] showing a change in...gender" as proof of identity to obtain, renew, or ***amend*** an Indiana driver's license or identification card. *See 140 Ind. Admin. Code 7-1.1-3(b)(1)(B) and (K)*.

Though never addressed by this court, the amendment of a birth certificate with respect to gender is not novel. The **[**5]** vast majority of states, including Indiana, have allowed it in practice for some time. *See In re Heilig, 372 Md. 692, 816 A.2d 68 (Md. 2003)* (recognizing that, at the time, twenty-two states had enacted statutes expressly enabling such amendments and twenty states had statutes dealing generally with amendments to birth certificates; only Tennessee statutorily forbade an amendment as to gender). *See also* Dean Spade, *Documenting Gender*, *59 Hastings L.J. 731, 768 (2008)* (forty-seven states allow gender reclassification on birth certificates (Idaho, Ohio, and Tennessee do not);[2] twenty-eight of these states "specifically authorize gender reclassification by statute or administrative ruling, while the other nineteen have no written rule stating that they allow sex designation change, but in practice do provide sex designation change upon application").[3]

I.C. § 16-37-2-10 provides general authority for the amendment of birth certificates, without any express limitation (in the statute or elsewhere) regarding gender amendments. In light of this statute, as well as the inherent equity power of a court of general jurisdiction, we conclude that the trial court had authority to grant the petition at hand. *See State ex. rel. Root v. Circuit Court of Allen County, 259 Ind. 500, 289 N.E.2d 503, 507 (Ind. 1972)* ("a court of general jurisdiction has inherent equity power unless a statute expressly or impliedly provides otherwise"). *See also In re Heilig, 816 A.2d at 82* ("[t]here is nothing extraordinary about equity jurisdiction in these kinds of matters").

We recognize the trial **[**7]** court's concern over what evidence is required in support of such a petition. In its order, the court queried in part:

> Can the court grant such a request merely because someone holds themselves out as a member of the other gender? If so, how long must they hold

---

[1] *In re Resnover, 979 N.E.2d 668 (Ind. Ct. App. 2012)*, addresses the need for a court-ordered name change for an individual to obtain an amendment to the name on a birth certificate.

[2] Tennessee is the only state that statutorily bans such amendments. *See Tenn. Code Ann. § 68-3-203(d)* (West, Westlaw current through end of the 2014 2nd Regular Session) ("[t]he sex of an individual shall not be changed on the original certificate of birth as a result of sex change surgery"). Ohio's denial is based on a ruling from a probate court interpreting Ohio's statute as "strictly a 'correction' type statute," which permits correction only "if in **[**6]** fact the original entry was in error." *In re Ladrach, 32 Ohio Misc. 2d 6, 8, 513 N.E.2d 828 (Ohio Prob. Ct. 1987)*. *See also Ohio Rev. Code Ann. § 3705.15* (providing for correction where registration of birth "has not been properly and accurately recorded"). The basis of Idaho's denial is unclear but commentators appear to agree that gender amendments are not permitted by Idaho's Office of Vital Statistics.

[3] The Model State Vital Statistics Act and Regulations issued by the U.S. Department of Health and Human Services has, since the 1977 revision, provided in § 21 for the amendment of a birth certificate upon the receipt of a certified copy of an order indicating the individual's sex has been changed by surgical procedure.

> themselves out as a member of the other gender? Is gender reassignment surgery required? Is hormone therapy required? Is a medical opinion required?

[*710] *Appendix* at 4. The legislature is free to craft specific requirements. Without such guidance, however, it is our view that the ultimate focus should be on whether the petition is made in good faith and not for a fraudulent or unlawful purpose.[4]

There can be no question in this case that Appellant made an adequate showing in support of his petition. He presented ample medical evidence regarding his gender transition, which culminated in sex reassignment surgery. Moreover, Appellant's genuine desire to have all identifying documents conform to his current physical and social identity is apparent.

The trial court erred in denying the petition. On remand, the trial court is directed to grant Appellant's petition and issue an order directing the ISDH to ***amend*** his ***birth certificate*** to reflect his male gender.

Reversed and remanded.

VAIDIK, C.J., and MAY, J., concur.

End of Document

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[4] The Social Security Administration (the SSA) recently began a new policy for individuals seeking to change their gender designation in their Social Security records. Previously, the SSA required documentation of sex reassignment surgery. This is no longer required. Under the new policy, individuals can submit, among other things, an ***amended birth certificate*** with the new sex, a court order directing legal recognition of the change of sex, or a physician's verified statement that "the individual has had appropriate clinical treatment for gender **[**8]** transition". Soc. Sec. Admin., Program Operations Manual Sys., RM 10212.200 Changing Numident Data for Reasons Other than Name Change (2013), available at https://secure.ssa.gov/poms.nsf/lnx/0110212200. *See also Admin. Law-Identity Records-Soc. Sec. Admin. Eliminates Surgical Requirement for Changing Trans Individuals' Gender Markers.-Soc. Sec. Admin., Program Operations Manual System, Rm 10212.200 Changing*, 127 Harv. L. Rev. 1863 (2014).

140 IAC 7-1.1-3

Current through June 13, 2018 Rules filed before May 19, 2018

Indiana Administrative Code > TITLE 140. BUREAU OF MOTOR VEHICLES > ARTICLE 7. DRIVER'S LICENSE DIVISION > RULE 1.1. DEFINITIONS; REQUIRED DOCUMENTATION FOR CREDENTIALS

140 IAC 7-1.1-3 License, permit, and identification card documentation requirements

Sec. 3.

(a) Each applicant for an initial, renewed, replacement, and amended driver's license and identification card must submit qualified documents or information, or both, to the bureau to prove the applicant's identity, lawful status in the United States (U.S.), residence address, and Social Security number (SSN) or that the applicant does not qualify for an SSN, and that the applicant is an Indiana resident. An applicant for an initial driver's license includes an applicant who held an Indiana driver's license or identification card, became a non-Indiana resident, and then reestablished Indiana residency. For some requirements, the bureau may allow applicants to use one (1) or more qualified documents to satisfy more than one (1) of the requirements in this section. A U.S. citizen, as verified through bureau records or the applicant's documents, who applies for a renewed, replacement, or amended driver's license or identification card and who otherwise qualifies for a driver's license or identification card but does not comply with the documentation requirements in this section may receive a driver's license or identification card with a notation that the driver's license or identification card may not be accepted for federal identification purposes. The bureau will only allow an applicant's documents to serve as proof for the applicable requirement in this section if the documents meet the following requirements:

(1) Must be unaltered and valid original documents or certified facsimiles from the issuing agency.

(2) Must be:

(A)in the English language; or

(B)presented with a verifiably accurate English translation of the document.

(b) All applicants for an initial, renewed, replacement, or amended Indiana driver's license or identification card must comply with the requirements in this subsection one (1) time, except for non-U.S. citizens, as verified through bureau records or the applicant's documents, who must comply with the requirements in this subsection each time the applicant applies for an initial, renewed, replacement, or amended Indiana driver's license or identification card. This subsection does not apply to a U.S. citizen, as verified through bureau records or the applicant's documents, who applies for a renewed, replacement, or amended driver's license or identification card with a notation that the driver's license or identification card may not be accepted for federal identification purposes. An applicant must show proof of the following:

(1) Identity, which includes full legal name and date of birth, by presenting one (1) of the following documents:

(A) An unexpired U.S. passport or U.S. passport card.

(B)A certified ***birth certificate***, and if applicable a certified ***amended birth certificate*** showing a change in name, date of birth, or gender, filed with a state office of vital statistics, or equivalent state entity, in the applicant's state of birth.

EXHIBIT B

(C)A Consular Report of Birth Abroad issued by the U.S. State Department (Form FS-240, Form DS-1350, or Form FS-545).

(D) An unexpired U.S. Department of Homeland Security (DHS) or U.S. Immigration and Naturalization Service (INS) issued Permanent Resident Card (Form I-551) for those individuals whose authorized admittance and lawful status can be verified by the DHS.

(E) An unexpired DHS issued Employment Authorization Document (Form I-688B or Form I-766) for those individuals whose authorized admittance and lawful status can be verified by the DHS.

(F) An unexpired foreign passport with an unexpired U.S. visa accompanied by the approved I-94 form documenting either the applicant's most recent admittance into the U.S. or current status, or an unexpired foreign passport without a U.S. visa, for those individuals whose authorized admittance and lawful status can be verified by the DHS.

(G)A DHS issued Certificate of Naturalization (Form N-550 or Form N-570) for those individuals whose authorized admittance and lawful status can be verified by the DHS.

(H)A DHS issued Certificate of Citizenship (Form N-560 or Form N-561) for those individuals whose authorized admittance and lawful status can be verified by the DHS.

(I) Non-U.S. citizens, as verified through bureau records or the applicant's documents, who have complied with the requirements in this subsection at least one (1) time and thereafter received an Indiana driver's license or identification card may use the Indiana driver's license or identification card for proof of identity.

(J) Other documents that a U.S. federal agency issued to show identity if the bureau can verify that the document's information is accurate.

(K) An applicant whose full legal name, date of birth, or gender was changed and is different than how the corresponding information appears in any of the documents delineated in clauses (A) through (J) must show proof of the change by presenting additional documents supporting the change, which include:

(i)a marriage certificate;

(ii)a divorce decree;

(iii)a court order approving a name change or a date of birth change;

(iv)a certified ***amended birth certificate*** for a gender change; or

(v)a physician's signed and dated statement that "(insert applicant's name) successfully underwent all treatment necessary to permanently change (insert applicant's name) gender from (insert prior gender) to (insert new gender).".

(2) Lawful status in the U.S. by presenting:

(A)one (1) of the documents delineated in subdivision (1)(A) through (1)(H);

(B)a Notice of Action (Form I-797) document, if the bureau can verify that the DHS received it and has not denied action, and documents that a U.S. federal agency issued to show lawful status that pertain to the applicant's Notice of Action;

(C)proof of application for asylum in the United States (Form I-589) for those individuals whose authorized admittance and lawful status can be verified by the DHS; or

(D)other documents that a U.S. federal agency issued to show lawful status if the bureau can verify that the document's information is accurate and the person has lawful status in the U.S.

(3) Being an Indiana resident and of the applicant's residence address, which may not be a post office box, by submitting the bureau's form entitled "Indiana Residency Affidavit" by the following:

(A) An applicant who is an incapacitated person. A person who:

(i)is the applicant's legal guardian or caregiver;

(ii)is at least eighteen (18) years of age; and

(iii)resides with the applicant;

must sign the form at a license branch. The legal guardian or caregiver must show proof of identity by providing one

(1)document from the list in subdivision (1), proof of residence address by providing two (2) documents from the list in subdivision (4), providing information detailing their relationship to the applicant, providing the guardianship documents if applicable, and presenting a valid Indiana driver's license or identification card.

(B) Homeless applicants without a residence address. The applicant must provide a letter from the government entity or not-for-profit organization on its letterhead containing the entity or organization's name, address, and telephone number, and the legal representative's name, signature, and signature date. The legal representative must state in the letter that the entity or organization provides services to the applicant and will accept delivery of mail for the applicant.

(C) Applicants who are unable to comply with the requirements in clause (A), (B), (D), or (E). A person with whom the applicant resides must:

(i)sign the form at a license branch at the time of the application; and

(ii)present:

(AA)a valid Indiana driver's license or identification card;

(BB)proof of identity by providing one (1) document from the list in subdivision (1); and

(CC)proof of residence address by providing two (2) documents from the list in subdivision (4).

(D) An applicant who resides in a motor vehicle, including, but not limited, to a mobile home or motor home. Another person who is an Indiana resident with a residence address must:

(i)sign the form and attest that the applicant may use the person's residence address for record purposes; and

(ii)show proof of residence address by providing two (2) documents from the list provided in subdivision (4). The applicant must provide proof of paying Indiana income taxes for the current year or immediately prior year, and have current motor vehicle title and registration records with the bureau.

(E) Applicants with rural route mail delivery addresses. Each of these applicants must also provide a properly certified government issued document containing the applicant's name and description of the residence's location.

(4) Being an Indiana resident and of the applicant's residence address, which may not be a post office box, by submitting two (2) documents showing proof of being an Indiana resident and two (2) documents showing the applicant's residence address. Qualifying documents include the following:

(A)A U.S. Postal Service change of address confirmation (Form CNL107) containing the applicant's old and new addresses.

(B)A survey of the applicant's Indiana property produced by a licensed surveyor containing the applicant's name and residence address.

(C) An Indiana voter registration card.

(D)A utility company, credit card, doctor, or hospital bill:

(i)issued within sixty (60) days of the application date; and

(ii)containing the applicant's name and residence address.

(E)A residence mortgage or similar loan contract, or lease or rental contract, containing:

(i)the applicant's name and residence address; and

(ii)signatures from the parties needed to execute the agreement.

(F)A bank statement or bank transaction receipt, dated within sixty (60) days of the application date, containing the:

(i)bank's name and mailing address; and

(ii)applicant's name and residence address.

(G)A current motor vehicle loan payment book for a motor vehicle registered in the applicant's name, and containing the applicant's name and residence address.

(H)A current valid homeowner's, renter's, or car insurance policy dated within one (1) year of the application date, containing the applicant's name and residence address.

(I)A W-2 Form, property tax or excise tax bill, or Social Security Administration (SSA) or other pension or retirement annual benefits summary statement, dated with the current or immediately prior year, containing the applicant's name and residence address.

(J)A preprinted pay stub, dated within sixty (60) days of the application date, containing the:

(i)employer's name and address; and

(ii)applicant's name and residence address.

(K) An Indiana family and social services administration issued child support check stub, or Medicaid or Medicare benefit statement, dated within sixty (60) days of the application date, containing the applicant's name and address.

(L)A valid Indiana handgun permit containing the applicant's:

(i)name;

(ii)signature;

(iii)residence address; and

(iv)date of birth.

(M) First-class mail from any federal or state court or agency, dated within sixty (60) days of the application date, containing the applicant's name and residence address.

(N) Participants in the Indiana attorney general's address confidentiality program may use a post office box address and must present a valid active identification card issued to the applicant under IC 5-26.5.

(5) Having a valid SSN or that the person does not qualify for an SSN by presenting one (1) SSN document or an SSA document, dated within sixty (60) days of the application date, establishing that the person does not qualify for an SSN. The applicant's SSN, or SSA documentation showing that the applicant does not qualify for an SSN, presented to the bureau must match the information that the SSA has in its records for the SSN or for the SSA documentation. The following documents, containing the applicant's name and SSN, qualify to show proof of having a valid SSN:

(A)SSA issued Social Security card.

(B)A W-2 form.

(C)A Form 1099.

(D)A preprinted pay stub containing the employer's name.

(c) Subject to the requirements in subsection (b), to receive a replacement or renewed Indiana driver's license or identification card, an applicant must do the following:

(1) Verify that the applicant's:

(A)full legal name;

(B)date of birth;

(C)SSN; and

(D)residence address;

are current, accurate, and match the information existing in the bureau's records.

(2) Applicants without an SSN must present an SSA document, dated within sixty (60) days of the application date, establishing that the person does not qualify for an SSN.

(d) Subject to the requirements in subsection (b), to receive an amended Indiana driver's license or identification card an applicant must do the following:

(1) Provide the applicant's existing driver's license or identification card, or verify that the applicant's:

(A)full legal name;

(B)date of birth;

(C)SSN; and

(D)residence address;

are current, accurate, and match the information existing in the bureau's records.

(2) Applicants without an SSN must present an SSA document, dated within sixty (60) days of the application date, establishing that the person does not qualify for an SSN.

(3) Present qualified documentation as proof for the requested change as follows:

(A) To show proof of the applicant's new full legal name, the applicant must submit one (1) of the following documents:

(i) An unexpired U.S. passport or U.S. passport card.

(ii)A certified ***birth certificate***, and if applicable a certified ***amended birth certificate*** showing a change in name, date of birth, or gender, filed with a state office of vital statistics, or equivalent state entity, in the applicant's state of birth.

(iii)A Consular Report of Birth Abroad issued by the U.S. State Department (Form FS-240, Form DS-1350, or Form FS-545).

(iv) An unexpired U.S. Department of Homeland Security (DHS) or U.S. Immigration and Naturalization Service (INS) issued Permanent Resident Card (Form I-551).

(v) An unexpired DHS issued Employment Authorization Document (Form I-688B or Form I-766).

(vi) An unexpired foreign passport with an unexpired U.S. visa accompanied by the approved I-94 form documenting either the applicant's most recent admittance into the U.S. or current status, or an unexpired foreign passport without a U.S. visa for those individuals whose authorized admittance and status can be verified by the DHS.

(vii)A DHS issued Certificate of Naturalization (Form N-550 or Form N-570).

(viii)A DHS issued Certificate of Citizenship (Form N-560 or Form N-561).

(ix) Other documents that a U.S. federal agency issued to show identity if the bureau can verify that the document's information is accurate.

(x)A marriage certificate.

(xi)A divorce decree.

(xii) Adoption papers.

(xiii)A court ordered name change.

(B) To show proof of the applicant's ***amended*** date of birth, the applicant must submit one (1) of the following documents:

(i)A certified ***amended birth certificate***.

(ii)A court ordered date of birth change.

(C) To show proof of the applicant's gender change, the applicant must submit one (1) of the following documents:

(i)A certified ***amended birth certificate***.

(ii)A physician's signed and dated statement that "(insert applicant's name) successfully underwent all treatment necessary to permanently change (insert applicant's name) gender from (insert prior gender) to (insert new gender).".

(D) To show proof of the applicant's new residence address, the applicant must submit the Indiana residency affidavit

pursuant to subsection (b)(3), or two (2) of the documents from the list in subsection (b)(4).

(E) To show proof of the applicant's new SSN, the applicant must present one (1) of the documents from the list in subsection (b)(5) containing the applicant's new SSN.

(e) An applicant may petition the commissioner or the commissioner's designee to accept reasonable, authentic, and verifiable alternative documents upon the applicant proving that the applicant is reasonably unable to meet the requirements in this section. However, non-U.S. citizens, as verified through bureau records or the applicant's documents, may not use alternate documents to demonstrate lawful status.

Statutory Authority

Authority:

IC 9-14-8-3; IC 9-24

Affected:

IC 5-26.5; IC 9-24

History

HISTORY:

(Bureau of Motor Vehicles; *140 IAC 7-1.1-3*; filed Nov 12, 2009, 3:44 p.m.: 20091209-IR-140090169FRA, eff Jan 1, 2010; readopted filed Nov 24, 2015, 4:18 p.m.: 20151223-IR-140150108RFA; filed Oct 5, 2017, 9:34 a.m.: 20171101-IR-140160492FRA)

INDIANA ADMINISTRATIVE CODE

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How to Apply for a Passport
What Form Should I use?
Renew my Passport by Mail
Apply in Person
Children Under 16
Applicants Age 16 and 17
Passport Card
Change or Correct a Passport
Replace a Limited Validity Passport
Gender Designation Change
Apply Outside the United States
Get a Passport in a Hurry
Life-or-Death Emergencies
Frequently Asked Questions

Gender Designation Change

Passports are valid for different lengths of time depending on where you are in your gender transition.

Status of Gender Transition	Validity of Passport
You have had appropriate clinical treatment*	10 years (Adult) 5 years (Child under 16)
You are in the process of getting appropriate clinical treatment	2 years

*Your physician determines what appropriate clinical treatment is.

Requirements

You must apply using Form DS-11, unless you are replacing a limited-validity passport in your correct gender (see below). **In addition** to the regularly-required documents*, submit the following:

1. ID that resembles your current appearance
2. Passport photo that resembles your current appearance
3. A medical certification that indicates you are in the process of or have had appropriate clinical treatment for gender transition
4. Proof of legal name change (if applicable)

*See Apply in Person for all regularly-required passport documents.

Medical Certification

A signed, original statement from a licensed physician must be on office letterhead and include:

- Physician's full name, address, and telephone number
- Medical license or certificate number
- Issuing state or other jurisdiction of medical license/certificate

Helpful Links for Gender Designation Change

Apply In Person
Passport Forms
Passport Photos
LGBTI Travel Information

WHERE TO APPLY

Enroll in STEP

Subscribe to get up-to-date safety and security information and help us reach you in an emergency abroad.

EXHIBIT C

Passport Videos

- Language stating that:
  - He or she has a doctor/patient relationship with you
  - He or she has treated you or has reviewed and evaluated your medical history
  - You have had, or are in process of having, appropriate clinical treatment for transition to the updated gender (male or female)
- The statement must include, "I declare under penalty of perjury under the laws of the United States that the forgoing is true and correct."
- Medical certification **requirements are the same for a minor** as an adult.

A template medical certification is available for download here.

Replacing a Limited-Validity Passport

You may have received a limited-validity passport because your gender transition was still in process. To replace a limited-validity passport for a full validity passport, submit Form DS-5504 (at no additional cost). To use this form, you must apply within two years of your previous passport's issue date.

Submit the following:

- Your limited passport book
- Passport photo that resembles your current appearance
- A medical certification indicating you have had appropriate clinical treatment for gender transition

Description of specific treatments is not required. The certification from your physician is based on his or her judgment of your treatment needs. This is in accordance with standards and recommendations of the World Professional Association for Transgender Health (WPATH), recognized as the authority in this field by the American Medical Association (AMA).

Frequently Asked Questions

ALL +/−

Do I need to have the gender on my birth certificate and/or driver's license changed before I can get it changed on my passport?

What is "appropriate clinical treatment"?

Your physician determines what appropriate clinical treatment is according to acceptable medical practices, standards and guidelines, and certifies that you have had appropriate clinical treatment for gender transition to either male or female. **Surgery is not a requirement to get a U.S. passport.**

Is there a specific requirement needed to get a 10-year passport vs. a 2-year passport?

Yes. The medical certification you submit must either state that you are in the process of having appropriate clinical treatment (2-year passport) or have had appropriate clinical treatment (10-year passport for adults, 5-year passport for children under 16) for gender transition. The certification must be on office letterhead, from a licensed physician stating that she/he has either treated you or has reviewed and evaluated your medical history, and that she/he has a doctor/patient relationship with you. **Surgery is not a requirement to get a U.S. passport.**

Do I need to apply using Form DS-11?

Yes. The first time you are changing your gender marker in a passport, you must use Form DS-11. After that, you can renew by mail using Form DS-82, if you are eligible. Children under age 16 must use Form DS-11 and appear in-person with both parents/legal guardians when applying for a passport.

How do I update the gender marker on a passport for my child?

The medical certification requirements are the same for a child as they are for an adult. However, parental consent is required when the child is under age 16.

Can my therapist, psychologist, naturopath, etc. submit a medical certification?

No, the medical certification must be from a licensed physician – either a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.).

If I get a 2-year passport, do I have to submit a new photo when I extend to a 10-year passport?

Yes. Please keep in mind that the new photo must resemble your current appearance and meet the passport photo requirements.

If all of my domestic documents have already been updated (birth certificate, driver's license, etc.) do I still need a medical certification? Why?

Yes, you still need to submit a medical certification. We need this because the requirements for amending the gender marker on birth certificates and other domestic documents vary from state to state.

If I have a court order showing a legal gender change, do I still need to obtain a medical certification from a physician? Why?

Yes, you still need to submit a medical certification. We need this because the requirements for obtaining a court order changing gender vary from state to state.

If I identify neither as male or female, can I have a passport issued with a different gender?

No, the only genders available for a passport are male and female.

I followed the requirements on this page, but I got a letter requesting more information. What do I do now?

Please follow the instructions in the letter. If you have further questions, please contact the National Passport Information Center at 1-877-487-2778/ 1-888-874-7793 (TDD/TTY).

Will anyone ask me questions about my medical history besides what is stated in my medical certification?

No. No one, including acceptance agents and passport agency staff, should ask you anything regarding your medical history, other than for you to provide the required medical certification.

I had a bad customer experience. How can I complain?

To make a complaint, you can call the National Passport Information Center at 1-855-865-7755 or submit a complaint online through our Customer Survey.

Does my ID have to be in my current name?

No. Your ID can be in either your current or previous name, as long as you submit a court order documenting your name change to the current name.

Social Security

Program Operations Manual System (POMS)

TN 5 (06-13)

RM 10212.200 Changing Numident Data for Reasons other than Name Change

A. How we change Numident data

We only "correct" or "change" information that is on a prior Numident record when there is a documented keying error.

In cases of a keying error, you must review the prior Social Security number (SSN) application; however, do not presume there was a keying error. If you cannot review the prior application, obtain a new application with proper evidence. The individual must submit evidence showing the correct data or information (e.g., a BC to correct an individual's sex field information) with evidence established before the cycle date on the Numident entry where the keying error was made.

If an individual wishes to update information previously submitted to us, the individual must complete and submit an SSN replacement application with evidence supporting the update, and we will create a new record showing the new data and append it to the prior record(s) on the Numident.

Keying Errors: See Details

- For instructions on date of birth (DOB) changes on the Numident, see RM 10210.295.
- For instructions on correcting a coding error that resulted in an incorrect employment legend on the SSN card, see RM 10215.055.

B. How do you create a new Numident entry to update data on the Numident

1. Request evidence

Each individual requesting an update of information on a current Numident record must submit:

- an SSN application for a replacement SSN or card;
- evidence of identity to establish that he or she is the person on the record to whom SSA assigned the SSN; and
- evidence to support the update per the chart in RM 10212.200B.2 in this section.

EXHIBIT D

2. Obtain documentation

Use this table to determine the supporting documentation required for requested updates to the Numident and any additional actions needed.

NOTE: These procedures apply to updates only. In cases of keying errors, see the instructions in RM 10212.200A in this section.

For this update	Obtain this supporting documentation and follow any additional instructions
Sex field	Accept any of the following: • full-validity, 10-year U.S. passport with the new sex **NOTE:** Do not accept passports with less than ten years of validity.; • State-issued amended BC with the new sex; • court order directing legal recognition of change of sex; • medical certification of appropriate clinical treatment for gender transition in the form of an original signed statement from a licensed physician (i.e., a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.)). The statement must include the following: ○ physician's full name; ○ medical license or certificate number; ○ issuing state, country, or other jurisdiction of medical license or certificate; ○ address and telephone number of the physician; ○ language stating that the individual has had appropriate clinical treatment for gender transition to the new gender (male or female); ○ language stating the physician has either treated the individual in relation to the individual's change in gender or has reviewed and evaluated the medical history of the individual in relation to the individual's change in gender and that the physician has a doctor/patient relationship with the individual; ○ language stating "I declare under penalty of perjury under the laws of the United States that the forgoing is true and correct." **NOTE:** See RM 10212.200C in this section for a sample letter from a licensed physician that includes all required information to certify to the individual's gender change.

For this update	Obtain this supporting documentation and follow any additional instructions
	IMPORTANT: Surgery is no longer required to change the sex field on the Numident. However, if an individual presents an original or certified letter from a physician stating the individual has undergone sexual reassignment surgery, accept it as evidence to change the sex field when it meets the requirements in GN 00301.030 and contains sufficient biographical data (e.g., name, date of birth) to clearly identify the individual. **NOTE:** In some cases an individual's sex may impact eligibility for benefits dependent upon spousal relationships. To make title II entitlement or title XVI eligibility determinations dependent upon marriage, follow the instructions in GN 00305.005B. **Do not use sex field data on SSA records to make marital status determinations.**
Date of birth field	See Date of Birth Change on the Numident, in RM 10210.295.
Place of birth (PLB) field	• U.S. born: a BC • foreign born: an acceptable document such as a BC or an acceptable proof of age document listed in kinds of documents that establish age for an SSN card in RM 10210.265, provided the document also list the individual's PLB.

For this update	Obtain this supporting documentation and follow any additional instructions
Citizenship field	Evidence of U.S. citizenship: • U.S. public birth record showing birth in one of the 50 U.S. states, the District of Columbia, American Samoa, Puerto Rico, Guam, the Virgin Islands of the U.S. (on or after 01/17/1917), or the Northern Mariana Islands (on or after 11/04/1986 (NMI Local time), • U.S. passport, • Certificate of Naturalization, • Certificate of Citizenship, or • Other documents listed in RM 10210.505, RM 10210.510, RM 10210.520, and RM 10210.525. Interviewers should request and obtain from the individual, the U.S. citizenship document with the highest evidence level available (i.e., the document exists or the individual can obtain the U.S. document within 10 working days) before accepting a document of a lower level. You may use primary, secondary, third-level, or fourth-level evidence to change the citizenship data on a Numident record. **EXAMPLE:** If **primary evidence** of U.S. citizenship is not available (does not exist or the individual cannot obtain the primary evidence in 10 working days), then the interviewer may accept **secondary evidence** to change the citizenship data on the Numident record.
Parent's name field	• original or amended BC, or • final adoption decree issue by the court or court determination of paternity

3. Process the request

If you change the sex code on the Numident, and the individual is:

- receiving Social Security benefits,
- receiving Supplemental Security Income (SSI) payments, or
- a representative payee for his or her child,

change the sex immediately if it is different on the Master Benefit Record (MBR), the Supplemental Security Record (SSR), or in the Representative Payee System (RPS) to agree with the Numident. List all documents or evidence submitted to change the individual's sex code on the Social Security Number Application Process (SSNAP) Summary screen.

NOTE: For instructions on determining whether a valid marital relationship exists, see GN 00305.005B.

When changing a parent's name on a child's Numident record, ask the parent if he or she is a title II beneficiary, an SSI recipient, or a representative payee. If so, review the MBR, SSR, or RPS record and initiate or complete actions necessary to update the record (e.g., correcting a parent's name on the SSR record or ensuring that actions are taken to complete a new representative payee application).

In the "Remarks" block on the SSNAP Summary screen, list any evidence or documents the individual submitted to change the following fields on the Numident, if not previously captured in SSNAP:

- sex field, or
- PLB field, or
- parent's name field.

4. When to suppress an SSN card

Process the requested change but **suppress** the issuance of a replacement SSN card when the correction will not affect any data on the face of the SSN card (i.e., changes to the sex, DOB, PLB, or parent's name fields on the Numident) **and** the individual is still in possession of the SSN card showing the correct information.

5. When to send written notice

Send a written notice if you are unable to provide an individual with an original or replacement SSN or card. Follow the appropriate instructions in:

- RM 00299.020 Form SSA-L676 – Refusal to Process SSN Application, or
- RM 10205.090 Form SS-5 Received and Additional Documentation is Needed, or
- RM 10215.110 Policy on Providing Written Notice and Second Review When SSN or Card May Not Be Issued, or
- RM 10215.115 Procedures for Providing Written Notice to an SSN Applicant.

See Details:

- RM 10210.265 Kinds of Documents that Establish Age for an SSN Card
- RM 10210.295 Date of Birth Change on the Numident
- RM 10210.505 Primary Level Evidence of U.S. Citizenship
- RM 10210.510 Secondary Level Evidence of U.S. Citizenship for a U.S. Born Applicant
- RM 10210.520 Third Level Evidence of U.S. Citizenship for a U.S. Born Applicant
- RM 10210.525 Fourth Level Evidence of U.S. Citizenship for a U.S. Born Applicant

- RM 10215.055 Correct a Coding Error that Resulted in an Incorrect Employment Legend on the SSN Card
- RM 10220.210 Evidence Requirements for Documentation of Harassment, Abuse, or Life Endangerment (HALE)
- GN 00301.030 Acceptability of Documentary Evidence
- GN 00301.080 Certification by Custodian of the Record
- GN 00301.045 Validity of Documents

C. Exhibit – Sample Letter from Licensed Physician Certifying to the Individual's Gender Change

(Physician's Address and Telephone Number)

I, (physician's full name), (physician's medical license or certificate number), (issuing U.S. State/Foreign Country of medical license/certificate), am the physician of (name of patient), with whom I have a doctor/patient relationship and whom I have treated (or with whom I have a doctor/patient relationship and whose medical history I have reviewed and evaluated).

(Name of patient) has had appropriate clinical treatment for gender transition to the new gender (specify new gender, male or female).

I declare under penalty of perjury under the laws of the United States that the forgoing is true and correct.

Signature of Physician

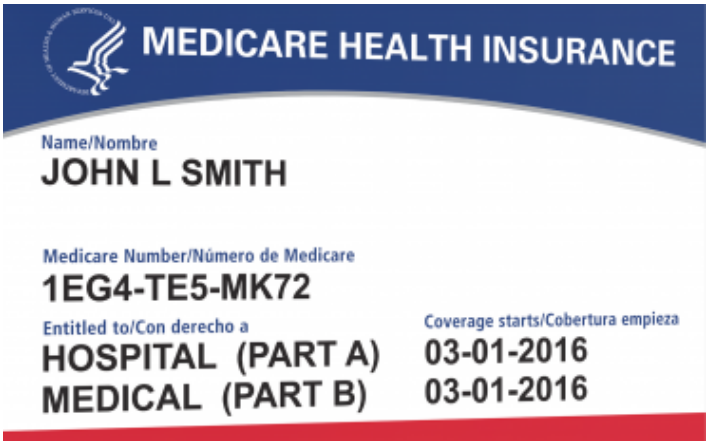
Typed Name of Physician

Date

TRANSGENDER EQUALITY
Celebrating 15 Years

Know Your Rights (/Know-Your-Rights) | Medicare

- Choose -



Medicare is one of America's most important health programs, providing health insurance for millions of older adults and people with disabilities. As with private insurance, transgender people sometimes encounter confusion about what is covered or barriers to accessing coverage—both for transition-related care and for routine preventive care. This document provides an overview of benefit questions that may arise for transgender people and information on what to do in response to an initial denial of coverage.

Download: Medicare and Transgender People (https://transequality.org/sites/default/files/docs/kyr/MedicareAndTransPeople.pdf)

What Does Medicare Cover for Transgender People?

Medicare covers routine preventive care regardless of gender markers.
Medicare covers routine preventive care for all eligible persons, including mammograms, pelvic and prostate exams. Medicare and many private plans may initially refuse coverage of services that seem to not match the gender of the person in Social Security records. Medicare and insurers often have a computer-matching program that only allows services to be paid for if the gender "marker matches," as a means of preventing mistakes and fraud in billing. This has the unintended consequence of denying claims for procedures that many transgender people need. However, Medicare beneficiaries have a right to access services that are appropriate to their individual medical needs and necessary care should be provided regardless of the gender marker in one's Social Security or other records. Later in this document we discuss what to do when coverage is wrongly denied due to an apparent gender mis-match.

EXHIBIT E

Medicare covers medically necessary hormone therapy.
Medicare also covers medically necessary hormone therapy for transgender people. These medications are part of Medicare Part D prescription drug plan formularies (lists of covered medications) and should be covered when prescribed. Sometimes coverage may be initially wrongly refused due to an apparent inconsistency of the hormones with a gender marker in a person's records. Nevertheless, Medicare beneficiaries have a right to access prescription drugs that are appropriate to their medical needs.

Medicare covers medically necessary sex reassignment surgery.
For many years, Medicare did not cover sex reassignment surgery for transgender people due to a decades-old policy that categorized such treatment as "experimental." That exclusion was eliminated in May 2014, and there is now no national exclusion for transition-related health care under Medicare. This means that coverage decisions for transition-related surgeries will be made individually on the basis of medical need and applicable standards of care, similar to other doctor or hospital services under Medicare.

What Happened to the Medicare Transgender Exclusion?

In 1989, Medicare adopted a National Coverage Determination categorically excluding what it called "Transsexual Surgery" from Medicare coverage, regardless of a person's individual medical conditions and needs. In May 2014, the U.S. Department of Health and Human Services (HHS) Departmental Appeals Board decided an appeal from a Medicare beneficiary and decided that the 1989 exclusion was based on outdated, incomplete, and biased science, and did not reflect contemporary medical science or standards of care. Accordingly, the Medicare policy of categorically excluding coverage of transition-related surgery, regardless of medical need, was invalidated. This means coverage decisions for transition-related care will now be made on an individual basis like all other services under Medicare.

What Do I Do if Coverage is Denied?

Original Medicare
To address inappropriate denials of coverage for preventive care and other services that are typically thought of as gender-specific, the Center for Medicare and Medicaid Services (CMS) has approved a special billing code (condition code 45) to assist processing of claims under original Medicare (Parts A and B). This billing code should be used by your physician or hospital when submitting billing claims for services where gender mis-matches may be a problem. When used with standard billing codes doctors use for specific procedures, this code alerts Medicare's computer system to ignore an apparent gender mis-match and allow your claim to be processed. Details are explained in the Chapter 32 of the Medicare Claims Processing Manual (see the Resources section below).

If you experience a denial of coverage you belief to be inappropriate (including coverage of preventive services that cannot be resolved as described above, or coverage of transition-related care), you may file an appeal, as described below.

Private Medicare (Medicare Advantage, Medicare Cost Plus or Medicare Part D, etc.)
These plans should also cover routine preventive care and transition-related care for transgender people, however, the Medicare override "condition code 45" cannot be used for private Medicare Advantage plans.

If you have a Medicare Advantage, Medicare Cost Plus or Medicare Part D plan and you are informed that your plan will not cover a service that is medically appropriate for you (for example, when a pharmacist tells you your plan will not cover your prescription hormones), the first thing you need to do is request a written "coverage determination" from the plan. This request must be submitted with a doctor's statement explaining the medical necessity of the item or service to be covered. Submit any documentation you can provide from your doctor supporting the medical necessity of the item or service. For prescription drugs, it's best to use Medicare's "Model Coverage Determination Request" form (see the Resources section below).

Appealing a negative coverage determination:
If you have original Medicare and a claim has been denied (for example, when Medicare refuses to cover your doctor visits or doctor-recommended surgery), you have the option of appealing that determination within 120 days, pursuant to the standard appeal procedures for all Medicare claims. The first level of appeal is called a "redetermination." You, or your doctor, or any other person whom you appoint (such as a family member or friend) can call or write to the company that handles your Medicare claims, as indicated on your most recent Medicare Summary Notice, and ask them to cover your claim. your Medicare claims, as indicated on your most recent Medicare Summary Notice, and ask them to cover your claim.

If another person is going to assist you in this process, you should contact the company to learn how to appoint this person to be your representative.

Once the company receives your appeal, they usually take one week to inform you of their decision (though faster appeals are possible in some circumstances). If their answer, called a “redetermination,” is unfavorable, there are several additional levels of possible review by Medicare and ultimately by a court. Review Medicare’s page “How do I file an appeal?” for more details (see the Resources section below).

If a private Medicare plan denies coverage, the appeals process is similar to original Medicare, but you must start by submitting an appeal to the plan. You, your doctor or your representative will typically need to file an appeal within 60 days with your plan, usually in writing (though some plans will allow appeals to be made by phone). Specific appeal procedures vary by plan, and are specified in each plan’s materials. For more information, see the Medicare page “How do I file an appeal?” and the resource “Medicare Prescription Drugs Coverage: How to Request a Coverage Determination, File an Appeal, or File a Complaint” (see the Resources section below).

How Do I Change the Gender Marker on My Medicare Card?

Original Medicare (Parts A and B) beneficiary cards list gender on the front of the card. This gender marker is to the gender in your Social Security Administration (SSA) record. If you change the gender in your SSA record, you may request a replacement card reflecting the change. For more information on changing your SSA record, see NCTE’s resource "Transgender People and the Social Security Administration." NCTE continues to advocate that the gender marker be removed from Medicare cards entirely.

What If I Am Treated With Disrespect?

If you encounter disrespect, discrimination, harassment or other inappropriate treatment related to your gender identity or transgender status, you may make a complaint with the appropriate entity. For problems when making inquiries or appeals in a private Medicare plan, you may file a complaint or grievance with your plan. For any other customer service problems, we recommend contacting your regional Center for Medicare and Medicaid Services (CMS) office. We encourage you to also share your experience with NCTE to aid in our advocacy efforts.

Information About Filing Appeals and Complaints

How Do I File an Appeal?
http://www.medicare.gov/claims-and-appeals/file-an-appeal/appeals.html (http://www.medicare.gov/claims-and-appeals/file-an-appeal/appeals.html)

Medicare Prescription Drug Coverage: How to Request a Coverage Determination, File an Appeal, or File a Complaint
http://www.cms.gov/partnerships/downloads/11112.pdf
(http://www.cms.gov/partnerships/downloads/11112.pdf)

Forms and other information for prescription drug appeals
https://www.cms.gov/MedPrescriptDrugApplGriev/ (https://www.cms.gov/MedPrescriptDrugApplGriev/)

Contact Information for Regional CMS (Medicare) Offices
CMS Regional Offices (http://www.cms.gov/About-CMS/Agency-Information/RegionalOffices/index.html?redirect=/RegionalOffices/)

Additional Resources

For general Medicare information
1-800-MEDICARE (633-4227)

Medicare Claims Processing Manual, Chapter 32 - Addressing Gender Discrepancies (See Section 240)
http://www.cms.gov/manuals/downloads/clm104c32.pdf
(http://www.cms.gov/manuals/downloads/clm104c32.pdf)

Medicare Interactive - A Resource from the Medicare Rights Center
http://www.medicareinteractive.org (http://www.medicareinteractive.org)

Medicare & You 2014 Handbook
http://www.medicare.gov/publications/pubs/pdf/10050.pdf
(http://www.medicare.gov/publications/pubs/pdf/10050.pdf)

(http://transequality.org)

(202) 642-4542

ncte@transequality.org (mailto:ncte@transequality.org)

1133 19th St NW
Suite 302
Washington D.C. 20036

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IHSAA Executive Committee

Thursday, June 22, 2017
French Lick, Indiana

Present
Chairwoman Debb Stevens, Mike Broughton, Jim Brown, Victor Bush, Steve Cox, Nathan Dean, Don Gandy, Ed Gilliland, Tim Grove, Jimmie Howell, Richard Lance, Charlie Martin, Patti McCormack, Paul Neidig, Debb Stevens, Brian Strong, Mike Whitten, Rae Woolpy, Dave Worland; Commissioner Bobby Cox, Assistant Commissioners Robert Faulkens, Phil Gardner, Chris Kaufman, Kerrie Schludecker, Sandra Walter, IT Director Luke Morehead, Sports Information Director Jason Wille, Attorney Bob Baker.

Minutes
The minutes of the May 1, 2017 meeting were recommended for approval.

A motion for approval was made by Tim Grove; seconded by Don Gandy; motion approved 19-0.

Approve Recognition of the Indiana High School Volleyball Coaches Association
Assistant Commissioner Kerrie Schludecker requested recognition of the newly-formed Indiana High School Volleyball Coaches Association (IHSVCA) following last month's Executive Committee meeting appearance by Jean Kesterson, president of the group, who discussed the group's efforts and overall philosophy.

A motion for approval was made by Ed Gilliland; seconded by Stacy Adams; motion approved 19-0.

Approve Changes to IHSAA Policy Manual

- **Withdrawal from Tournament Series Policy**
  Commissioner Bobby Cox spoke on a baseball sectional situation that occurred where a school withdrew from the sectional tournament after the drawing allowing their opponent to automatically receive a bye into the championship game:

  "If it becomes necessary for a School to withdraw from the Tournament Series, the School must notify the IHSAA, and the host principal of the sectional or other Tournament Series venue, immediately after the School discovers its inability to participate in the Tournament Series.

  A member School, which has entered an IHSAA Tournament Series in a sport, and withdraws from a Tournament Series after the drawing has been completed for that Tournament Series, or forfeits a Tournament Series contest in a team sport by failing to attend the contest or by failing to field a competition team for a Tournament Series contest, shall be fined Two Hundred Dollars ($200.00) and placed on probation in that sport for a Three Hundred Sixty-five (365) days.

  In the event a School withdraws from an IHSAA Tournament Series after the drawing has been completed and the withdrawal results in a member School advancing to the championship game or match in that sectional without playing another School, that specific sectional draw shall be redrawn if the withdrawing occurs prior to the beginning of play in that specific sectional."

  A motion for approval was made by Mike Broughton; seconded by Jim Brown; motion approved 19-0.

- **IHSAA Gender Policy**
  Commissioner Bobby Cox and attorney Robert Baker discussed the new language that will be added to the IHSAA Gender Policy.

  "A student may only participate on a team of the gender which matches the gender of the student at birth (birth gender), unless the provision of IHSAA Rule 9-9 or IHSAA Rule 9-10 apply or as hereinafter provided. A student's birth gender may be established by the original birth certificate issued at birth, provided however, if the birth certificate is unavailable or the birth certificate does not show gender, birth gender can be established by the student's contemporaneous medical records from the birth or other reliable documents and evidence.

  The IHSAA rules do not permit transgender or transsexual, cross-dressing or similar types of student-athletes to participate on a member School's team which is other than the team of the gender which matches the student's birth gender, unless there is a changed gender.

  A student can demonstrate that the student's birth gender has changed (changed gender), and then participate on a team of the changed gender, but may never later participate on a team of the prior gender, even if the student later transitions to the prior or birth gender.

  Trans-Female Student-Athlete (MTF). A student whose birth gender was male and has changed to female can establish the changed gender by the following:

  a. *First, the MTF student shall declare that the gender has changed from male to female, that the MTF student intends to participate as a female, that the MTF student understands and agrees that after the MTF student participates on a team of the female gender, that the MTF student may never later participate on a team of the male gender, and*

  b. *Second, provide reliable medical evidence that:*

     i. *the MTF student has undergone sex change before puberty, or*

     ii. *the MTF student-athlete has undergone sex change after puberty, which should include evidence that surgical and anatomical changes have been completed, including genitalia changes and gonadectomy, that all hormonal therapies have been administered in a verifiable manner, that sufficient length of time has occurred such as to minimize gender-related advantages and all legal recognition of the sex change has been conferred with all proper governmental agencies (A copy of the MTF student's amended birth certificate, a court order or other official state determination showing the MTF student's new gender will suffice).*

  In addition, to verify a MTF student's changed gender, the MTF student may be required to submit to a confidential case-by-case evaluation by an IHSAA Gender Committee relative to the gender change.
  Trans-Male Student-Athlete (FTM). A student whose birth gender was female and has changed to male can prove the student's changed gender by the following:

  a. *First, the FTM student shall declare that the gender has changed from female to male, that the FTM student intends to participate as a male, that the FTM student understands and agrees that after the FTM student participates on a team of the male gender, that the FTM student may never later participate on a team of the female gender, and*

  b. *Second, provide reliable medical evidence that the FTM student is taking or has complete a regime of medically prescribed testosterone for the purposes of gender transition."*

A motion for approval was made by Richard Lance; seconded by Charlie Martin; motion approved 19-0.

Approve Adjustments to Previously Approved Realignment for Football
Victor Bush raised concern with the Class 6A football realignment that was passed at the May 1 meeting and requested reconsideration of a proposed realignment he has submitted.

A motion for approval was made by Victor Bush; seconded by Tim Grove; motion failed 1-18 with Victor Bush voting in support of the proposal.

Approve Major Technology Project Expenditures
Technology Director Luke Morehead spoke on necessary upgrades and improvements to the IHSAA.net website to serve the member schools and requested permission to hire WDD Software of Indianapolis to execute this project.

A motion for approval was made by Mike Broughton; seconded by Jim Brown; motion approved 19-0.

Approve Probationary Members of the IHSAA for Full Membership

- Assistant Commissioner Sandra Walter reported on Christel House Academy and recommended full membership approval.

  A motion to approve Christel House Academy for full membership was made by Dave Worland; seconded by Richard Lance; motion approved 19-0.

- Assistant Commissioner Kerrie Schludecker reported on Indianapolis Lighthouse Charter South and recommended full membership approval.

  A motion to approve Indianapolis Lighthouse Charter for full membership was made by Ed Gilliland; seconded by Steve Cox; motion approved 18-1 with Victor Bush dissenting.

- Assistant Commissioner Chris Kaufman reported on Providence Cristo Rey and recommended full membership approval.

  A motion to approve Providence Cristo Rey was made by Charlie Martin; seconded by Richard Lance; motion approved 19-0.

- Assistant Commissioner Phil Gardner reported on Smith Academy for Excellence and recommended full membership approval.

  A motion to approve Smith Academy for Excellence was made by Stacy Adams; seconded by Brian Strong; motion approved 19-0.

Approve 2017-18 Boys Tennis Tournament Series
Assistant Commissioner Chris Kaufman reported on the general format, sites and other preliminary plans for the 2017-18 Boys Tennis Tournament Series.

SECTIONALS	**SEPTEMBER 27-30, 2017**		
Sectional 1	**Sectional 2**	**Sectional 3**	**Sectional 4**
Alexandria	***Avon***	Bedford North Lawrence	***Bremen***

Anderson
Anderson Prep Academy
Elwood
Frankton
Lapel
Brownsburg
Danville
Mooresville
Plainfield

Bloomington North
Bloomington South
Edgewood
Martinsville
Glenn
LaVille
Plymouth
Triton

Sectional 5
Carmel
Guerin Catholic
University

Westfield

Sectional 6
Carroll (Fort Wayne)
Churubusco
Fort Wayne Blackhawk Christian
Fort Wayne Snider
Fort Wayne Northrop
Leo

Sectional 7
Center Grove
Franklin Community
Greenwood Community

Indian Creek
Whiteland Community

Sectional 8
Brown County
Columbus East
Columbus North

Edinburgh
Hauser

Sectional 9
Concord
Elkhart Central
Elkhart Memorial
Northridge

Sectional 10
Connersville
Franklin County
Rushville
Union County

Sectional 11
Crawfordsville
North Montgomery
Rockville
Southmont
Turkey Run

Sectional 12
Crown Point
Kankakee Valley
Lake Central
Lowell
Rensselaer Central
Hanover Central

Sectional 13
Knox
North Judson
Culver Academies
Rochester

Sectional 14
DeKalb
Fremont
Angola
Prairie Heights

Sectional 15
Muncie Burris
Muncie Central
Delta
Yorktown

Sectional 16
East Chicago Central
Gary Roosevelt
Gary West Side
Hammond Bishop Noll
Hammond Clark
Hammond Morton

Sectional 17
Central Noble

East Noble
Lakeland
West Noble
Westview

Sectional 18
Evansville Bosse

Evansville Day
Evansville Harrison
Evansville North
Evansville Reitz Memorial

Sectional 19
Crawford County

Eastern (Pekin)
Floyd Central
North Harrison
Salem

Sectional 20
Fort Wayne Concordia Lutheran
Fort Wayne Dwenger
Fort Wayne North Side
Fort Wayne South Side
New Haven

Sectional 21
Attica
Benton Central
Covington
Fountain Central
Seeger

Sectional 22
Beech Groove
Franklin Central
Indianapolis Lutheran
Roncalli

Sectional 23
Bethany Christian
Fairfield
Goshen
Jimtown
Northwood

Sectional 24
Fishers
Hamilton Heights
Hamilton Southeastern
Noblesville

Sectional 25
Fort Wayne Canterbury
Fort Wayne Luers
Fort Wayne Wayne

Sectional 26
Forest Park
Jasper
Pike Central

Sectional 27
Randolph Southern
Union City
Winchester

Sectional 28
Clarksville
Jeffersonville
New Washington

Homestead
Southridge

Jay County
Providence

Sectional 29
Greensburg
Jennings County
Madison Consolidated
Shawe Memorial
Southwestern (Hanover)

Sectional 30
Eastern (Greentown)
Kokomo
Northwestern
Taylor
Tipton
Western

Sectional 31
Marquette Catholic
Michigan City
LaPorte
New Prairie

Sectional 32
Heritage Christian
Indianapolis Arlington
Lawrence Central
Lawrence North
Warren Central

Sectional 33
Frankfort
Lebanon
Rossville
Western Boone
Zionsville

Sectional 34
Carroll (Flora)
Cass
Delphi
Logansport
Twin Lakes

Sectional 35
Barr-Reeve
Loogootee
Northeast Dubois
Paoli
Springs Valley

Sectional 36
Blackford
Madison-Grant
Marion
Mississinewa

Sectional 37
Andrean
Gary Wallace
Hobart
Lake Station
Merrillville
River Forest

Sectional 38
Evansville Central
Evansville Mater Dei
Evansville F.J. Reitz
Mount Vernon
North Posey

Sectional 39
Eastern Hancock
Greenfield-Central
Mount Vernon (Fortville)
New Palestine
Pendleton Heights

Sectional 40
Calumet
Griffith
Hammond
Hammond Gavit
Highland
Munster

Sectional 41
Corydon Central
Lanesville
New Albany
South Central (Elizabeth)

Christian Academy of Indiana

Sectional 42
Blue River Valley
Knightstown
New Castle
Shenandoah

Tri

Sectional 43
Indianapolis Broad Ripple
Indianapolis Chatard
Indianapolis Cathedral
North Central(Indianapolis)

Sectional 44
Bloomfield
Linton-Stockton
North Daviess
White River Valley

Sectional 45
Greencastle
Owen Valley
Northview
South Putnam
South Vermillion

Sectional 46
Adams Central
Bellmont
Bluffton
Huntington North
Norwell
South Adams

Sectional 47
Mishawaka Marian
Mishawaka
Penn
South Bend Adams

Sectional 48
Maconaquah
Manchester
Peru
Wabash

Sectional 49
Brebeuf Jesuit
Indpls. Arsenal Technical
International
Park Tudor
Pike

Sectional 50
Gibson Southern
Princeton Community
Tecumseh
Wood Memorial
Heritage Hills

Sectional 51
Chesterton
Portage
Valparaiso
Wheeler

Sectional 52
Cambridge City Lincoln
Centerville
Hagerstown
Northeastern
Richmond

Sectional 53

Sectional 54

Sectional 55

Sectional 56

Austin
Brownstown Central
Scottsburg
Seymour
Trinity Lutheran

Morristown
Shelbyville
Southwestern (Shelbyville)
Triton Central
Waldron

Borden
Charlestown
Henryville
Silver Creek

South Bend Clay
South Bend Riley
South Bend St. Joseph
South Bend Washington

Sectional 57
Batesville
East Central
Lawrenceburg
Milan
Oldenburg Academy
South Dearborn

Sectional 58
Decatur Central
Indianapolis Scecina
Perry Meridian
Southport
Indianapolis Shortridge

Sectional 59
Ben Davis
Covenant Christian (Indpls.)
Indpls. Cardinal Ritter
Indpls. Crispus Attucks
Indpls. Northwest
Speedway

Sectional 60
Boonville
Castle
Heritage Hills
South Spencer
Tell City

Sectional 61
North Central (Farmersburg)
Sullivan
Terre Haute North
Terre Haute South
West Vigo

Sectional 62
South Knox
Vincennes Lincoln
Vincennes Rivet
Washington
Washington Catholic
Sullivan

Sectional 63
Columbia City
Tippecanoe Valley
Warsaw Community
Wawasee
Whitko

Sectional 64
Harrison (W. Lafayette)
Lafayette Central Catholic
Lafayette Jefferson
McCutcheon
West Lafayette

REGIONALS **OCTOBER 3-4, 2017**

Regional 1
Avon
Ben Davis
Brownsburg
Lebanon

Regional 2
Carroll (Fort Wayne)
Fort Wayne Concordia
Homestead
Norwell

Regional 3
Center Grove
Franklin Central
Shelbyville
Southport

Regional 4
Concord
DeKalb
East Noble
Goshen

Regional 5
Crawfordsville
Fountain Central
Northview
Terre Haute North

Regional 6
Bremen
Culver Academies
Peru
Warsaw

Regional 7
Evansville Bosse
Mount Vernon
Princeton
Tell City

Regional 8
Jasper
Loogootee
North Daviess
Vincennes Lincoln

Regional 9
Carmel
Kokomo
Logansport
West Lafayette

Regional 10
Anderson
Delta
Jay County
Marion

Regional 11
Crown Point
East Chicago Central
Merrillville
Munster

Regional 12
Hamilton Southeastern
Lawrence North
Mount Vernon (Fortville)
North Central (Indianapolis)

Regional 13
LaPorte
Penn
Portage
South Bend Clay

Regional 14
Connersville
New Castle
Richmond
South Dearborn

Regional 15
Bloomington North
Columbus North
Jennings County
Seymour

Regional 16
Floyd Central
Jeffersonville
New Albany
Silver Creek

SEMI-STATE **October 7, 2017**

Semi-State 1	**Semi-State 2**	**Semi-State 3**	**Semi-State 4**
Avon	***Jasper***	***Homestead***	***Culver Academies***
Center Grove	Evansville Bosse	Carroll (Fort Wayne)	Kokomo
Crawfordsville	Bloomington North	Concord	Munster
Richmond	Silver Creek	Marion	Portage
		North Central (Indpls.)	

State
Two Winners from Center Grove, Culver Academies, Homestead, Jasper
Team Quarterfinals Hosts: Carmel and Center Grove (October 13, 2017)
Team Championship Host: North Central (Indianapolis) (October 14, 2017)
Individual Host: Park Tudor (October 20-21, 2017)

A motion to approve the recommendations for the Boys Tennis Tournament Series was made by Tim Grove; seconded by Jim Brown; motion approved 19-0.

Approve 2017-18 Boys & Girls Cross Country Tournament Series
Assistant Commissioner Phil Gardner reported on the general format, sites and other preliminary plans for the 2017-18 Boys and Girls Cross Country Tournament Series.

Sectionals October 7, 2017

Sectional 1	**Sectional 2**	**Sectional 3**	**Sectional 4**
Calumet	21st Century Charter -Gary	***Chesterton***	Kankakee Valley
East Chicago Central	Andrean	Boone Grove	Knox
Gary West Side	Bowman Leadership Academy	Lake Station Edison	Kouts
Griffith	***Crown Point***	LaPorte	LaCrosse
Hammond Academy of Science & Technology	Lighthouse CPA	Marquette Catholic	Morgan Township
Hammond Bishop Noll	Gary Roosevelt	Michigan City	North Judson-San Pierre
Hammond	Hanover Central	New Prairie	North Newton
Hammond Clark	Hebron	Portage	Oregon-Davis
Hammond Gavit	Hobart	South Central (Union Mills)	***Rensselaer Central***
Hammond Morton	Lowell	Valparaiso	South Newton
Highland	Merrillville	Washington Township	West Central
Lake Central	River Forest	Westville	
Munster		Wheeler	
Whiting			

Sectional 5	**Sectional 6**	**Sectional 7**	**Sectional 8**
Attica	Clinton Central	Argos	Carroll (Flora)
Benton Central	Clinton Prairie	Caston	Cass
Crawfordsville	Delphi Community	***Culver Academies***	Eastern (Greentown)
Covington	Faith Christian	Culver Community	Kokomo
Fountain Central	Frankfort	Manchester	***Logansport***
Frontier	***Harrison (West Lafayette)***	North Miami	Maconaquah

North Montgomery
North Vermillion
North White
Seeger
Southmont
Tri-County
Twin Lakes
Lafayette Central Catholic
Lafayette Jefferson
McCutcheon
Rossville
West Lafayette
Western Boone
Plymouth
Rochester Community
Tippecanoe Valley
Triton
Warsaw Community
Northwestern
Peru
Pioneer
Taylor
Western
Winamac Community

Sectional 9
Bremen
Glenn
LaVille
Mishawaka
Mishawaka Marian
Penn
South Bend Adams
South Bend Career Academy
South Bend Clay
South Bend Riley
South Bend Saint Joseph
South Bend Washington

Sectional 10
Bethany Christian
Concord
Elkhart Central
Elkhart Christian Academy
Elkhart Memorial
Fairfield
Goshen
Jimtown
Northridge
NorthWood
Wawasee

Sectional 11
Angola
Central Noble
Churubusco
DeKalb
East Noble
Eastside
Fremont
Lakeland
Prairie Heights
West Noble
Westview

Sectional 12
Carroll (Fort Wayne)
Columbia City
Fort Wayne Blackhawk Christian
Fort Wayne Concordia Lutheran
Fort Wayne Bishop Dwenger
Fort Wayne Northrop
Fort Wayne Northside
Fort Wayne Snider
Garrett
Homestead
Lakewood Park Christian
Leo
Whitko

Sectional 13
Adams Central
Bellmont
Bluffton
Fort Wayne Canterbury
Fort Wayne Bishop Luers
Fort Wayne Southside
Fort Wayne Wayne
Heritage
New Haven
Norwell
South Adams
Woodlan

Sectional 14
Blackford
Eastbrook
Huntington North
Madison-Grant
Marion
Mississinewa
Northfield
Oak Hill
Southern Wells
Southwood
Wabash

Sectional 15
Alexandria Monroe
Anderson
Anderson Preparatory Academy
Blue River Valley
Daleville
Elwood Community
Frankton
Lapel
Liberty Christian
Mt. Vernon (Fortville)
Pendleton Heights
Shenandoah
Yorktown

Sectional 16
Cowan
Delta
Jay County
Monroe Central
Muncie Burris
Muncie Central
Randolph Southern
Union (Modoc)
Union City
Wapahani
Wes-Del
Winchester Community

Sectional 17
Avon
Bethesda Christian
Brownsburg
Cascade

Sectional 18
Ben Davis
Covenant Christian (Indpls)
Decatur Central
Herron

Sectional 19
Carmel
Fishers
Guerin Catholic
Hamilton Heights

Sectional 20
Brebeuf Jesuit Preparatory
Heritage Christian
Indiana School for the Deaf
Indianapolis Arlington

Cloverdale
Danville Community
Greencastle
North Putnam
Plainfield
South Putnam
Tri-West Hendricks
Indiana Math & Science Academy
Indianapolis Crispus Attucks
Indianapolis Northwest
Indianapolis Shortridge
Indianapolis George Washington
International School of Indiana
Pike
Speedway
Zionsville
Hamilton Southeastern
Lebanon
Noblesville
Sheridan
Tindley
Tipton
University
Westfield
Indianapolis Arsenal Technical
Indianapolis Bishop Chatard
Indianapolis Broad Ripple
Indianapolis Cardinal Ritter
Indianapolis Cathedral
Lawrence Central
Lawrence North
North Central (Indpls.)
Park Tudor

Sectional 21
Beech Grove
Eastern Hancock
Franklin Central
Greenfield-Central
Indianapolis Emmerich Manual
Indianapolis Lutheran
Indianapolis Marshall
Indianapolis Scecina Memorial
Morristown
New Palestine
Roncalli
Triton Central
Warren Central

Sectional 22
Cambridge City
Centerville
Connersville
Franklin County
Hagerstown
Knightstown
New Castle
Northeastern
Richmond
Rushville Consolidated
Seton Catholic
Tri
Union County

Sectional 23
Batesville
East Central
Greensburg
Jac-Cen-Del
Milan
North Decatur
Oldenburg Academy
Rising Sun
South Dearborn
South Decatur
South Ripley

Sectional 24
Center Grove
Eminence
Franklin Community
Greenwood Community
Greenwood Christian Academy
Monrovia
Mooresville
Perry Meridian
Shelbyville
Southport
Waldron
Whiteland Community

Sectional 25
Brown County
Brownstown Central
Columbus East
Columbus North
Crothersville
Edinburgh
Hauser
Indian Creek
Martinsville
Seymour
Southwestern (Shelbyville)
Trinity Lutheran
White River Valley

Sectional 26
Clay City
Linton-Stockton
North Central (Farmersburg)
Northview
Owen Valley
Riverton Parke
Rockville
Shakamak
South Vermillion
Sullivan
Terre Haute North
Terre Haute South
West Vigo

Sectional 27
Bedford North Lawrence
Bloomfield
Bloomington North
Bloomington South
Eastern Greene
Eastern (Pekin)
Edgewood
Medora
Mitchell
Orleans
Paoli
Salem
West Washington

Sectional 28
Austin
Charlestown
Henryville
Jennings County
Madison Consolidated
New Washington
Rock Creek Academy
Scottsburg
Shawe Memorial
Silver Creek
Southwestern (Hanover)
Switzerland County

Sectional 29

Sectional 30

Sectional 31

Sectional 32

Borden	Cannelton	Barr-Reeve	Boonville
Christian Academy Of Indiana	Forest Park	Gibson Southern	Castle
Clarksville	Heritage Hills	North Daviess	Evansville Bosse
Corydon Central	***Jasper***	North Knox	Evansville Central
Crawford County	Loogootee	Pike Central	Evansville Harrison
Floyd Central	Northeast Dubois	Princeton Community	***Evansville Mater Dei***
Jeffersonville	Perry Central	***South Knox***	Evansville Reitz Memorial
Lanesville	Shoals	Tecumseh	Evansville North
New Albany	South Spencer	Vincennes Lincoln	Evansville F.J. Reitz
North Harrison	Southridge	Vincennes Rivet	Mt. Vernon
Providence	Springs Valley	Washington	North Posey
South Central (Elizabeth)	Tell City	Washington Catholic	Signature

Regionals - October 14, 2017

Regional 1	**Regional 2**	**Regional 3**	**Regional 4**
Crown Point	***New Prairie***	***Harrison (West Lafayette)***	***Culver Academies***
Crown Point	Chesterton	Benton Central	Culver Academies
Hammond Gavit	Rensselaer Central	Harrison (West Lafayette)	Logansport

Regional 5	**Regional 6**	**Regional 7**	**Regional 8**
Elkhart Central	***West Noble***	***Marion***	***Delta***
Elkhart Central	Fort Wayne Northrop	Bellmont	Delta
South Bend Riley	West Noble	Marion	Pendleton Heights

Regional 9	**Regional 10**	**Regional 11**	**Regional 12**
Ben Davis	***Noblesville***	***Rushville Consolidated***	***Shelbyville***
Ben Davis	Brebeuf Jesuit Preparatory	Connersville	Franklin Community
South Putnam	Noblesville	New Palestine	South Dearborn

Regional 13	**Regional 14**	**Regional 15**	**Regional 16**
Brown County	***Bedford North Lawrence***	***Crawford County***	***Pike Central***
Brown County	Bedford North Lawrence	Crawford County	Evansville Mater Dei
Southwestern (Hanover)	Terre Haute North	Jasper	South Knox

Semi-States - October 21, 2017

Semi State 1	**Semi State 2**	**Semi State 3**	**Semi State 4**
Brown County	***Carmel***	***New Haven***	***New Prairie***
Bedford North Lawrence	Ben Davis	Delta	Crown Point
Brown County	Noblesville	Elkhart Central	Culver Academies
Crawford County	Rushville Consolidated	Marion	Harrison (West Lafayette)
Pike Central	Shelbyville	West Noble	New Prairie

State Championship on October 28, 2017 at LaVern-Gibson Cross Country Course, Terre Haute.

A motion to approve the recommendations for the Boys & Girls Cross Country Tournament Series was made by Mike Whitten; seconded by Ed Gilliland; motion approved 18-1 with Stacy Adams dissenting.

Approve 2017-18 Football Tournament Series

Assistant Commissioner Robert Faulkens reported on the general format and other preliminary plans for the 2017-18 Football Tournament Series.

Class 6A (32 Schools)

Sectional 1	Sectional 2	Sectional 3	Sectional 4
Crown Point	Chesterton	Carroll (Fort Wayne)	Carmel
Lake Central	Penn	Fort Wayne Northrop	Lafayette Jefferson
Merrillville	Valparaiso	Fort Wayne Snider	Noblesville
Portage	Warsaw	Homestead	Westfield
Sectional 5	**Sectional 6**	**Sectional 7**	**Sectional 8**
Fishers	Ben Davis	Avon	Center Grove
Hamilton Southeastern	Lawrence Central	Brownsburg	Columbus North
North Central (Indpls.)	Lawrence North	Perry Meridian	Franklin Central
Pike	Warren Central	Southport	Jeffersonville

Class 5A (37 Schools)

Sectional 9	Sectional 10	Sectional 11	Sectional 12
LaPorte	Concord	Harrison (West Lafayette)	Anderson
Michigan City	Elkhart Central	Huntington North	Greenfield-Central
Munster	Elkhart Memorial	Kokomo	Muncie Central
South Bend Adams	Fort Wayne North Side	McCutcheon	New Palestine
	Goshen		Zionsville
Sectional 13	**Sectional 14**	**Sectional 15**	**Sectional 16**
Decatur Central	Bloomington North	Bedford North Lawrence	Castle
Indianapolis Arsenal Technical	Bloomington South	Columbus East	Evansville North
Indianapolis Cathedral	Franklin Community	Floyd Central	Terre Haute North Vigo
Plainfield	Martinsville	New Albany	Terre Haute South Vigo
Roncalli	Whiteland Community	Seymour	

Class 4A (64 Schools)

Sectional 17	Sectional 18	Sectional 19	Sectional 20
East Chicago Central	Hobart	Angola	Columbia City
Gary West Side	Kankakee Valley	Culver Academies	Fort Wayne Bishop Dwenger
Griffith	Mishawaka	DeKalb	Fort Wayne South Side
Hammond	New Prairie	East Noble	Fort Wayne Wayne
Hammond Gavit	South Bend Clay	Northridge	Jay County
Hammond Morton	South Bend Riley	NorthWood	Leo
Highland	South Bend Saint Joseph	Plymouth	Logansport
Lowell	South Bend Washington	Wawasee	New Haven
Sectional 21	**Sectional 22**	**Sectional 23**	**Sectional 24**

Delta	Beech Grove	East Central	Boonville
Frankfort	Connersville	Edgewood	Evansville Bosse
Lebanon	Greenwood Community	Franklin County	Evansville Central
Marion	Mooresville	Jennings County	Evansville F.J. Reitz
Mississinewa	Mt. Vernon (Fortville)	Madison Consolidated	Evansville Harrison
Pendleton Heights	New Castle	Scottsburg	Jasper
Western	Richmond	Silver Creek	Northview
Yorktown	Shelbyville	South Dearborn	Owen Valley

Class 3A (64 Schools)

Sectional 25	**Sectional 26**	**Sectional 27**	**Sectional 28**
Andrean	Blackford	Fairfield	Bellmont
Benton Central	Brebeuf Jesuit Preparatory	Glenn	Fort Wayne Bishop Luers
Calumet	Crawfordsville	Jimtown	Fort Wayne Concordia Lutheran
Hammond Clark	Guerin Catholic	Knox	Garrett
Hanover Central	Hamilton Heights	Maconaquah	Heritage
Twin Lakes	North Montgomery	Mishawaka Marian	Lakeland
West Lafayette	Northwestern	Peru	Norwell
Wheeler	Southmont	Tippecanoe Valley	West Noble

Sectional 29	**Sectional 30**	**Sectional 31**	**Sectional 32**
Indian Creek	Brown County	Batesville	Evansville Reitz Memorial
Indianapolis Crispus Attucks	Danville Community	Brownstown Central	Gibson Southern
Indianapolis Bishop Chatard	Greencastle	Charlestown	Heritage Hills
Indianapolis Broad Ripple Magnet	Monrovia	Corydon Central	Mt. Vernon
Indianapolis Cardinal Ritter	South Vermillion	Greensburg	Pike Central
Indianapolis Emmerich Manual	Sullivan	Lawrenceburg	Princeton Community
Indianapolis Northwest	Tri-West Hendricks	North Harrison	Vincennes Lincoln
Rushville Consolidated	West Vigo	Salem	Washington

Class 2A (64 Schools)

Sectional 33	**Sectional 34**	**Sectional 35**	**Sectional 36**
Boone Grove	Bluffton	Cass	Alexandria
Bowman Leadership Academy	Bremen	Delphi Community	Elwood
Gary Roosevelt	Central Noble	Eastbrook	Frankton
Hammond Bishop Noll	Manchester	Eastern (Greentown)	Lapel
Lake Station Edison	Prairie Heights	Oak Hill	Madison-Grant
North Newton	Wabash	Rensselaer Central	Northeastern
River Forest	Whitko	Rochester Community	Shenandoah
Whiting	Woodlan	Taylor	Winchester Community

Sectional 37	**Sectional 38**	**Sectional 39**	**Sectional 40**
Centerville	Cascade	Clarksville	Evansville Mater Dei

Eastern Hancock	Cloverdale	Crawford County	Forest Park
Heritage Christian	Indianapolis George Washington	Eastern (Pekin)	Linton-Stockton
Indianapolis Scecina Memorial	North Putnam	Mitchell	North Knox
Knightstown	Park Tudor	Paoli	North Posey
Milan	Speedway	Perry Central	South Spencer
Triton Central	Tipton	Providence	Southridge
Union County	Western Boone	Switzerland County	Tell City
	Western Boone		

Class 1A (63 Schools)

Sectional 41	**Sectional 42**	**Sectional 43**	**Sectional 44**
Caston	Carroll (Flora)	Adams Central	Anderson Preparatory Academy
Culver Community	Frontier	Churubusco	Clinton Central
LaVille	Lafayette Central Catholic	Eastside	Clinton Prairie
North Judson-San Pierre	North Miami	Fremont	Monroe Central
South Central (Union Mills)	North White	Northfield	Sheridan
Triton	Pioneer	South Adams	Tri-Central
West Central	South Newton	Southern Wells	Union City
Winamac	Tri-County	Southwood	Wes-Del

Sectional 45	**Sectional 46**	**Sectional 47**	**Sectional 48**
Covenant Christian (Indpls.)	Cambridge City Lincoln	Attica	Eastern Greene
Indiana School for the Deaf	Edinburgh	Covington	North Central (Farmersburg)
Indianapolis Arlington	Hagerstown	Fountain Central	North Daviess
Indianapolis Howe Academy	Indianapolis Lutheran	North Vermillion	Rock Creek Academy (2018)
Indianapolis Shortridge	North Decatur	Riverton Parke	Springs Valley
South Putnam	Oldenburg Academy	Rockville	Tecumseh
Tindley	South Decatur	Seeger	West Washington
Traders Point Academy (2018)	Tri	Turkey Run	Wood Memorial

	6A	**5A**	**4A**	**3A**	**2A**	**1A**
Regionals	**Winners of Sec. Games**	**Winners of Sec. Games**	**Winners of Sec. Games**	**Winners of Sec. Games**	**Winners of Sec. Games**	**Winners of Sec. Games**
Game 1	1 vs 2	9 vs 10	17 vs 18	25 vs 26	33 vs 34	41 vs 42
2	3 vs 4	11 vs 12	19 vs 20	27 vs 28	35 vs 36	43 vs 44
3	5 vs 6	13 vs 14	21 vs 22	29 vs 30	37 vs 38	45 vs 46
4	7 vs 8	15 vs 16	23 vs 24	31 vs 32	39 vs 40	47 vs 48
Semi-States Game	**Winners of Reg. Games**	**Winners of Reg. Games**	**Winners of Reg. Games**	**Winners of Reg. Games**	**Winners of Reg. Games**	**Winners of Reg. Games**
	(1) 1 vs 2	**(3)** 5 vs 6	**(5)** 9 vs 10	**(7)** 13 vs 14	**(9)** 17 vs 18	**(11)** 21 vs 22
	(2) 3 vs 4	**(4)** 7 vs 8	**(6)** 11 vs 12	**(8)** 15 vs 16	**(10)** 19 vs 20	**(12)** 23 vs 24

State	Winners of SS Games 1 vs 2 (11/25)	Winners of SS Games 3 vs 4 (11/24)	Winners of SS Games 5 vs 6 (11/25)	Winners of SS Games 7 vs 8 (11/24)	Winners of SS Games 9 vs 10 (11/25)	Winners of SS Games 11 vs 12 (11/24)

A motion to approve the recommendations for the 2017-18 Football Tournament Series was made by Richard Lance; seconded by Ed Gilliland; motion approved 18-1 with Victor Bush dissenting.

Approve 2017-18 Girls Golf Tournament Series

Assistant Commissioner Chris Kaufman reported on the general format, sites and other preliminary plans for the 2017-18 Girls Golf Tournament Series.

Sectionals

Sectional 1	Sectional 2	Sectional 3	Sectional 4
Andrean	Boone Grove	Culver Academies	Kankakee Valley
Calumet	Chesterton	Glenn	Lowell
Crown Point	Hanover Central	Knox	North Judson-San Pierre
Griffith	LaCrosse	***LaPorte***	North Newton
Hammond Bishop Noll	Merrillville	Marquette Catholic	Pioneer
Highland	Portage	Michigan City	Rensselaer Central
Hobart	***Valparaiso***	New Prairie	South Newton
Lake Central	Westville	Oregon Davis	***Twin Lakes***
Munster		South Central (Union Mills)	West Central
			Winamac Community

Sectional 5	Sectional 6	Sectional 7	Sectional 8
Benton Central	Cass	Elkhart Central	Carroll (Fort Wayne)
Clinton Central	Eastern (Greentown)	Elkhart Memorial	Columbia City
Clinton Prairie	Kokomo	LaVille	Concord
Delphi Community	Logansport	Mishawaka	***East Noble***
Frankfort	Maconaquah	Mishawaka Marian	Fairfield
Harrison (West Lafayette)	North Miami	***Penn***	Goshen
Lafayette Central Catholic	Northwestern	South Bend Adams	Jimtown
Lafayette Jefferson	Peru	South Bend Clay	Northridge
McCutcheon	Taylor	South Bend Riley	Prairie Heights
Rossville	Tipton	South Bend Saint Joseph	West Noble
West Lafayette	***Western***	South Bend Washington	Westview

Sectional 9	Sectional 10	Sectional 11	Sectional 12
Angola	Bremen	Adams Central	Blackford
Churubusco	Caston	Bellmont	Eastbrook
DeKalb	Lakeland Christian Academy	Bluffton	***Huntington North***
Fort Wayne Blackhawk Christian	Northwood	Fort Wayne Bishop Luers	Madison-Grant
Fort Wayne Concordia Lutheran	Plymouth	Fort Wayne Canterbury	Manchester

Fort Wayne Bishop Dwenger
Fort Wayne North Side
Fort Wayne Northrop
Fort Wayne Snider
Fremont
Hamilton
Leo
Rochester Community
Tippecanoe Valley
Triton
Warsaw Community
Wawasee
Whitko
Fort Wayne South Side
Fort Wayne Wayne
Heritage
Homestead
New Haven
Norwell
South Adams
Southern Wells
Marion
Mississinewa
Northfield
Oak Hill
Southwood
Wabash

Sectional 13
Alexandria Monroe
Anderson
Elwood Community
Fishers
Hamilton Heights
Hamilton Southeastern
Lapel
Noblesville
Shenandoah

Sectional 14
Blue River Valley
Daleville
Delta
Jay County
Monroe Central
Muncie Central
Union (Modoc)
Wapahani
Wes-Del
Winchester Community
Yorktown

Sectional 15
Heritage Christian
Indianapolis Broad Ripple
Indianapolis Cathedral
Indianapolis Bishop Chatard
Indianapolis Crispus Attucks
Lawrence Central
Lawrence North
North Central (Indianapolis)
Park Tudor
Warren Central

Sectional 16
Eastern Hancock
Greenfield-Central
Greenwood Community
Greenwood Christian Academy
Knightstown
Mt. Vernon (Fortville)
New Palestine
Pendleton Heights
Shelbyville
Triton Central
Southwestern (Shelbyville)

Sectional 17
Cambridge City Lincoln
Centerville
Connersville
Franklin County
Hagerstown
New Castle
Northeastern
Richmond
Tri
Union County

Sectional 18
Batesville
Columbus East
Columbus North
East Central
Greensburg
Jac-Cen-Del
Milan
North Decatur
Oldenburg Academy
Rushville Consolidated
South Ripley
South Decatur

Sectional 19
Ben Davis
Brebeuf Jesuit Preparatory
Carmel
Covenant Christian
Guerin Catholic
Indianapolis Cardinal Ritter
Indianapolis Northwest
Pike
Speedway
Westfield
University

Sectional 20
Attica
Crawfordsville
Lebanon
North Montgomery
North Putnam
Seeger
Southmont
Western Boone

Sectional 21
Avon
Brownsburg
Cascade
Danville Community
Decatur Central
Monrovia
Mooresville
Plainfield
Tri-West Hendricks

Sectional 22
Beech Grove
Center Grove
Franklin Central
Franklin Community
Indianapolis Scecina Memorial
Perry Meridian
Roncalli
Shortridge
Southport

Sectional 23
Cloverdale
Greencastle
Northview
Rockville
South Putnam
South Vermillion
Terre Haute North
Terre Haute South
West Vigo

Sectional 24
Austin
Henryville
Jennings County
Lawrenceburg
Madison
Scottsburg
Shawe Memorial
Southwestern (Hanover)
South Dearborn

Zionsville
Whiteland Community
Switzerland County

Sectional 25
Borden
Charlestown
Christian Academy of Indiana
Clarksville
Corydon Central
Floyd Central
Jeffersonville
New Albany
North Harrison
Providence
Silver Creek
South Central (Elizabeth)

Sectional 26
Boonville
Crawford County
Forest Park
Gibson Southern
Heritage Hills
Jasper
South Spencer
Southridge
Tecumseh
Tell City

Sectional 27
Castle
Evansville Bosse
Evansville Central
Evansville Harrison
Evansville Mater Dei
Evansville Reitz Memorial
Evansville North
Evansville F.J. Reitz
Mount Vernon
North Posey
Signature

Sectional 28
Barr-Reeve
Linton-Stockton
North Daviess
North Knox
Pike Central
Princeton Community
South Knox
Sullivan
Vincennes Lincoln
Vincennes Rivet
Washington

Sectional 29
Bedford North Lawrence
Brownstown Central
Eastern (Pekin)
Mitchell
Orleans
Paoli
Salem
Seymour
Springs Valley
Trinity Lutheran

Sectional 30
Bloomington North
Bloomington South
Brown County
Eastern Greene
Edgewood
Edinburgh
Indian Creek
Martinsville
Owen Valley

Regionals
(1) Lafayette Jefferson @ Battleground GC (Sectionals 1-6)
(2) East Noble @ Noble Hawk GC (Sectionals 7-12)
(3) Lapel @ Edgewood GC (Sectionals 13-18)
(4) Roncalli @ Legends GC (Sectionals 19-24)
(5) Washington @ Country Oaks GC (Sectionals 25-30)

State Finals
Prairie View Golf Club, Carmel

A motion to approve the recommendations for the Girls Golf Tournament Series was made by Patti McCormack; seconded by Don Gandy; motion approved 19-0.

Approve 2017-18 Girls & Boys Soccer Tournament Series
Assistant Commissioner Sandra Walter reported on the general format, sites and other preliminary plans for the 2017-18 Girls and Boys Soccer Tournament Series.

Girls: Class 3A

Sectional 1
Sectional 2
Sectional 3
Sectional 4

Crown Point
East Chicago Central
Hammond Morton
Lake Central
Lowell
Munster
Chesterton
Hobart
Merrillville
Michigan City
Portage
Valparaiso
LaPorte
Mishawaka
Penn
South Bend Adams
South Bend Riley
Concord
Elkhart Central
Elkhart Memorial
Goshen
Northridge

Sectional 5
Harrison (West Lafayette)
Kokomo
Lafayette Jefferson
Logansport
McCutcheon

Sectional 6
Carroll (Fort Wayne)
East Noble
Fort Wayne North Side
Fort Wayne Northrop
Fort Wayne Snider

Sectional 7
Fort Wayne South Side
Fort Wayne Wayne
Homestead
Huntington North
Warsaw Community

Sectional 8
Anderson
Fishers
Hamilton Southeastern
Muncie Central
Noblesville
Pendleton Heights

Sectional 9
Avon
Ben Davis
Brownsburg
Decatur Central
Mooresville
Plainfield

Sectional 10
Brebeuf
Carmel
Guerin Catholic
Pike
Westfield
Zionsville

Sectional 11
Indianapolis Arsenal Technical
Lawrence Central
Lawrence North
North Central (Indianapolis)
Perry Meridian
Southport

Sectional 12
East Central
Franklin Central
Greenfield-Central
Mt. Vernon (Fortville)
Richmond
Warren Central

Sectional 13
Center Grove
Columbus East
Columbus North
Franklin Community
Greenwood Community
Whiteland Community

Sectional 14
Bloomington North
Bloomington South
Martinsville
Terre Haute North Vigo
Terre Haute South Vigo

Sectional 15
Bedford North Lawrence
Floyd Central
Jeffersonville
Jennings County
New Albany
Seymour

Sectional 16
Castle
Evansville Central
Evansville F.J. Reitz
Evansville Harrison
Evansville North

Girls: Class 2A

Sectional 17
Andrean
Griffith
Hammond
Hammond Clark
Hammond Gavit
Highland

Sectional 18
Culver Academies
Benton Central
Hanover Central
Kankakee Valley
Twin Lakes
West Lafayette

Sectional 19
Glenn
Mishawaka Marian
Plymouth
South Bend Clay
South Bend St. Joseph
South Bend Washington

Sectional 20
Angola
DeKalb
Lakeland
NorthWood
Wawasee
West Noble

Sectional 21
Maconaquah
Marion

Sectional 22
Columbia City
Fort Wayne Bishop Dwenger

Sectional 23
Bellmont
Fort Wayne Bishop Luers

Sectional 24
Delta
Hamilton Heights

Mississinewa	Fort Wayne Concordia Lutheran	Heritage	Jay County
Peru	Garrett	New Haven	New Castle
Western	Leo	***Norwell***	***Yorktown***

Sectional 25	**Sectional 26**	**Sectional 27**	**Sectional 28**
Crawfordsville	Herron	Batesville	Beech Grove
Danville Community	***Indianapolis Bishop Chatard***	Franklin County	Connersville
Frankfort	Indianapolis Broad Ripple	Greensburg	New Palestine
Lebanon	Indianapolis Cathedral	***Lawrenceburg***	Rushville Consolidated
North Montgomery	Indianapolis Northwest	South Dearborn	***Shelbyville***
Tri-West Hendricks	Roncalli		

Sectional 29	**Sectional 30**	**Sectional 31**	**Sectional 32**
Brown County	Gibson Southern	Charlestown	Boonville
Edgewood	***Jasper***	Corydon Central	Evansville Bosse
Northview	Pike Central	***Madison Consolidated***	Evansville Reitz Memorial
Owen Valley	Princeton Community	North Harrison	***Heritage Hills***
Sullivan	Vincennes Lincoln	Scottsburg	Mt. Vernon
West Vigo	Washington	Silver Creek	

Girls: Class 1A

Sectional 33	**Sectional 34**	**Sectional 35**	**Sectional 36**
Hammond Bishop Noll	Boone Grove	Argos	***Bethany Christian***
Marquette Catholic	***Covenant Christian (DeMotte)***	Bremen	Central Noble
Morgan Township	Hebron	Culver Community	Elkhart Christian Academy
Washington Township	Kouts	***LaVille***	Lakeland Christian Academy
Westville	North White	North Miami	Lakewood Park Christian
Wheeler	Rensselaer Central	Rochester Community	Westview

Sectional 37	**Sectional 38**	**Sectional 39**	**Sectional 40**
Sheridan	Delphi Community	Blackford	***Fort Wayne Blackhawk Christian***
Tipton	Faith Christian	***Eastbrook***	Fort Wayne Canterbury
Tri-Central	Lafayette Central Catholic	Eastern (Greentown)	Manchester
University	***Northwestern***	Oak Hill	South Adams
Western Boone	Rossville	Taylor	Whitko
		Wabash	Woodlan

Sectional 41	**Sectional 42**	**Sectional 43**	**Sectional 44**
Cascade	Covenant Christian (Indianapolis)	Bethesda Christian	Centerville
Greencastle	Greenwood Christian Academy	Heritage Christian	***Knightstown***

Monrovia	***Indianapolis Cardinal Ritter***	Indianapolis Lutheran	Muncie Burris
North Putnam	Indianapolis Washington	Indianapolis Scecina Memorial	Union County
South Vermillion	International	Park Tudor	Wapahani
Southmont	Speedway	***Triton Central***	

Sectional 45	**Sectional 46**	**Sectional 47**	**Sectional 48**
Forest Park	Milan	Christian Academy of Indiana	Evansville Day
North Knox	Oldenburg Academy	***Providence***	Evansville Mater Dei
Northeast Dubois	***Rising Sun***	Salem	***North Posey***
South Knox	South Ripley	Southwestern (Hanover)	South Spencer
Vincennes Rivet	Switzerland County	Trinity Lutheran	Wood Memorial
Washington Catholic			

REGIONAL -- Saturday [4 Teams, 3 Game Tournament]

Class 3A

Regional 1	Regional 2	Regional 3	Regional 4
SB Adams	***Logansport***	***Zionsville***	***Bloomington South***
Goshen	Carroll (Fort Wayne)	Greenfield-Catholic	Bloomington South
Munster	Harrison (West Lafayette)	Guerin Catholic	Castle
Penn	Homestead	Lawrence North	Floyd Central
Portage	Noblesville	Plainfield	Greenwood Community

Class 2A

Regional 5	Regional 6	Regional 7	Regional 8
Plymouth	***Marion***	***New Palestine***	***Jasper***
Highland	Columbia City	Crawfordsville	Boonville
Lakeland	Marion	Indianapolis Bishop Chatard	Jasper
Plymouth	Norwell	Lawrenceburg	Madison Consolidated
West Lafayette	Yorktown	Shelbyville	Sullivan

Class 1A

Regional 9	Regional 10	Regional 11	Regional 12
Culver Community	***Northwestern***	***Heritage Christian***	***Forest Park***
Bethany Christian	Eastbrook	Indianapolis Cardinal Ritter	Forest Park
Covenant Christian (DeMotte)	Fort Wayne Blackhawk Christian	Knightstown	North Posey
LaVille	Northwestern	Southmont	Providence
Wheeler	Sheridan	Triton Central	Rising Sun

SEMI STATE -- Saturday [2 Teams, 2 Sites North, 2 Sites South) Assignments AFTER Regional Round

North - 1 (3 Games)	**North - 2 (3 Games)**	**South - 1 (3 Games)**	**South - 2 (3 Games)**

Kokomo	***SB St. Joseph***	***Evansville North***	***Lawrenceburg***
STATE TOURNAMENT	**Friday (2 Games) & Saturday (4 Games)**		**Classes to Play**
Friday, Oct. 27, 2017	Butler University	6:00 / 8:00 pm	TBD
Saturday, Oct. 28, 2017	IUPUI Michael Carroll Stadium	10:30/1:00/3:30/6:00	TBD

Boys: Class 3A

Sectional 1	**Sectional 2**	**Sectional 3**	**Sectional 4**
East Chicago Central	Chesterton	LaPorte	Concord
Hammond Morton	Crown Point	Mishawaka	Elkhart Central
Highland	Hobart	Penn	***Elkhart Memorial***
Lake Central	***Merrillville***	***South Bend Adams***	Goshen
Lowell	Michigan City	South Bend Clay	Northridge
Munster	Portage	South Bend Riley	Plymouth
	Valparaiso		

Sectional 5	**Sectional 6**	**Sectional 7**	**Sectional 8**
Harrison (West Lafayette)	Carroll (Fort Wayne)	Fort Wayne North Side	Anderson
Kankakee Valley	DeKalb	Fort Wayne South Side	Fishers
Kokomo	***East Noble***	Fort Wayne Wayne	***Hamilton Southeastern***
Lafayette Jefferson	Fort Wayne Bishop Dwenger	Homestead	Muncie Central
Logansport	Fort Wayne Northrop	Huntington North	Noblesville
McCutcheon	Fort Wayne Snider	***Warsaw Community***	Pendleton Heights

Sectional 9	**Sectional 10**	**Sectional 11**	**Sectional 12**
Avon	Brebeuf	Franklin Central	Connersville
Ben Davis	***Carmel***	Indianapolis Arsenal Technical	East Central
Brownsburg	Guerin Catholic	Indianapolis Cathedral	***Greenfield-Central***
Decatur Central	North Central (Indianapolis)	Lawrence Central	Mt. Vernon (Fortville)
Mooresville	Pike	Lawrence North	New Palestine
Plainfield	Westfield	***Warren Central***	Richmond
	Zionsville		Shelbyville

Sectional 13	**Sectional 14**	**Sectional 15**	**Sectional 16**
Center Grove	Bedford North Lawrence	Columbus East	Castle
Franklin Community	Bloomington North	Columbus North	Evansville Central
Greenwood Community	Bloomington South	Floyd Central	Evansville F.J. Reitz
Perry Meridian	Martinsville	Jeffersonville	***Evansville Harrison***
Roncalli	Terre Haute North Vigo	Jennings County	Evansville North
Southport	***Terre Haute South Vigo***	New Albany	Jasper
Whiteland Community		***Seymour***	

Boys: Class 2A

Sectional 17	Sectional 18	Sectional 19	Sectional 20
Griffith	Benton Central	Culver Academies	Angola
Hammond	***Hanover Central***	Glenn	Garrett
Hammond Bishop Noll	Rensselear Central	***Mishawaka Marian***	Lakeland
Hammond Clark	Twin Lakes	Rochester Community	NorthWood
Hammond Gavit	West Lafayette	South Bend St. Joseph	***Wawasee***
Lighthouse CPA	Wheeler	South Bend Washington	West Noble

Sectional 21	Sectional 22	Sectional 23	Sectional 24
Marion	Columbia City	***Bellmont***	Blackford
Mississinewa	Fort Wayne Concordia Lutheran	Fort Wayne Bishop Luers	Delta
Northwestern	***Maconaquah***	Heritage	Eastbrook
Oak Hill	Manchester	Leo	Jay County
Tipton	Peru	New Haven	Muncie Burris
Western	Tippecanoe Valley	Norwell	***New Castle***
		Woodlan	Yorktown

Sectional 25	Sectional 26	Sectional 27	Sectional 28
Crawfordsville	***Danville Community***	Brown County	Batesville
Frankfort	Indianapolis Bishop Chatard	Beech Grove	Franklin County
Hamilton Heights	Indianapolis Cardinal Ritter	Edgewood	Greensburg
Lebanon	Indianapolis Crispus Attucks	Herron	Lawrenceburg
North Montgomery	Indianapolis Northwest	Indianapolis Emmerich Manual	***Rushville Consolidated***
Southmont	Speedway	***Monrovia***	South Dearborn
Western Boone	Tri-West Hendricks		

Sectional 29	Sectional 30	Sectional 31	Sectional 32
Greencastle	Gibson Southern	Charlestown	Boonville
Northview	Pike Central	Corydon Central	Evansville Bosse
Owen Valley	Princeton Community	Madison Consolidated	Evansville Mater Dei
South Vermillion	Southridge	***North Harrison***	***Evansville Reitz Memorial***
Sullivan	Vincennes Lincoln	Salem	Heritage Hills
West Vigo	***Washington***	Scottsburg	Mt. Vernon
		Silver Creek	

Boys: Class 1A

Sectional 33	Sectional 34	Sectional 35	Sectional 36
Andrean	Bremen	Bethany Christian	***Argos***
Boone Grove	***Elkhart Christian Academy***	Central Noble	Caston
Covenant Christian (DeMotte)	LaVille	Eastside	Culver Community
Hammond Acad. of Sc & Math	Marquette Catholic	Hamilton	Lakeland Christian Academy

Hebron	South Bend Career Academy	Prairie Heights	North Miami
Kouts	Washington Township	***Westview***	Oregon-Davis
Morgan Township	Westville		Winamac Community

Sectional 37	**Sectional 38**	**Sectional 39**	**Sectional 40**
Fort Wayne Blackhawk Christian	Carroll (Flora)	Anderson Preparatory Academy	***Heritage Christian***
Fort Wayne Canterbury	Delphi Community	Eastern (Greentown)	Indianapolis Shortridge
Lakewood Park Christian	Faith Christian	Liberty Christian	International
South Adams	***Lafayette Central Catholic***	***Taylor***	Park Tudor
Wabash	North White	Tri-Central	Sheridan
Whitko	Rossville		University
	Tri-County		

Sectional 41	**Sectional 42**	**Sectional 43**	**Sectional 44**
Bethesda Christian	Centerville	Central Christian Academy	Greenwood Christian Academy
Cascade	***Knightstown***	Christel House Academy	Hauser
Covenant Christian (Indianapolis)	Seton Catholic	Indianapolis George Washington	***Indianapolis Lutheran***
Covington	Union City	Indianapolis Scecina Memorial	Morristown
Indiana Math & Science Academy	Union County	Irvington Preparatory Academy	Oldenburg Academy
North Putnam	Wapahani	***Providence Cristo Rey***	Southwestern (Shelbyville)

Sectional 45	**Sectional 46**	**Sectional 47**	**Sectional 48**
Mitchell	***Jac-Cen-Del***	Austin	Forest Park
North Knox	Milan	***Christian Academy of Indiana***	North Posey
Shoals	Rising Sun	Henryville	***Northeast Dubois***
South Knox	Shawe Memorial	Lanesville	South Spencer
Vincennes Rivet	South Ripley	Providence	Tell City
Washington Catholic	Southwestern (Hanover)	Rock Creek Academy	Wood Memorial
White River Valley	Switzerland County	Trinity Lutheran	

REGIONAL -- Saturday [4 Teams, 3 Game Tournament]

Class 3A

Regional 1	Regional 2	Regional 3	Regional 4
Merrillville	***Kokomo***	***North Central***	***Seymour***
East Chicago Central	East Noble	Avon	Evansville Harrison
Elkhart Memorial	Hamilton Southeastern	Carmel	Perry Meridian
Merrillville	Logansport	Greenfield-Central	Seymour
South Bend Adams	Warsaw Community	Warren Central	Terre Haute South

Class 2A

Regional 5	Regional 6	Regional 7	Regional 8
Mishawaka Marian	***Oak Hill***	***Greensburg***	***Heritage Hills***
Griffith	Bellmont	Danville Community	Evansville Reitz Memorial
Hanover Central	Maconaquah	Lebanon	North Harrison
Mishawaka Marian	New Castle	Monrovia	South Vermillion
Wawasee	Oak Hill	Rushville Community	Washington

Class 1A

Regional 9	Regional 10	Regional 11	Regional 12
Argos	***Taylor***	***Knightstown***	***Providence***
Argos	Fort Wayne Canterbury	Bethesda Christian	Christian Academy of IN
Covenant Christian (DeMotte)	Heritage Christian	Indianapolis Lutheran	Jac-Cen-Del
Elkhart Christian Academy	Lafayette Central Catholic	Knightstown	North Knox
Westview	Taylor	Providence Cristo Rey	Northeast Dubois

SEMI STATE -- Saturday [2 Teams, 2 Sites North, 2 Sites South) Assignments AFTER Regional Round

North - 1 (3 Games)	**North - 2 (3 Games)**	**South - 1 (3 Games)**	**South - 2 (3 Games)**
Kokomo	***SB St. Joseph***	***Evansville North***	***Lawrenceburg***
STATE TOURNAMENT	**Friday (2 Games) & Saturday (4 Games)**		**Classes to Play**
Friday, Oct. 27, 2017	Butler University	6:00 / 8:00 pm	TBD
Saturday, Oct. 28, 2017	IUPUI Michael Carroll Stadium	10:30/1:00/3:30/6:00	TBD

A motion to approve the Girls and Boys Soccer Tournament Series was made by Don Gandy; seconded by Victor Bush; motion approved 19-0.

Approve 2017-18 Volleyball Tournament Series

Assistant Commissioner Kerrie Schludecker reported on the general format, sites and other preliminary plans for the 2017-18 Volleyball Tournament Series.

Sectionals-October 10, 12, 14

Class 4A

Sectional 1	**Sectional 2**	**Sectional 3**	**Sectional 4**
Crown Point	Chesterton	LaPorte	Concord
East Chicago Central	Hobart	Mishawaka	Elkhart Central
Hammond Morton	Merrillville	Penn	Elkhart Memorial
Highland	Michigan City	Plymouth	Goshen
Lake Central	Portage	South Bend Adams	Northridge
Lowell	**Valparaiso**	**South Bend Clay**	**Warsaw Community**
Munster		South Bend Riley	

Sectional 5	**Sectional 6**	**Sectional 7**	**Sectional 8**
Carroll (Fort Wayne)	Fort Wayne North Side	Harrison (West Lafayette)	Anderson
DeKalb	Fort Wayne South Side	Kokomo	Carmel
East Noble	Fort Wayne Wayne	Lafayette Jefferson	Fishers
Fort Wayne Concordia Lutheran	Homestead	Logansport	Hamilton Southeastern
Fort Wayne Northrop	Huntington North	**McCutcheon**	**Noblesville**
Fort Wayne Snider	Muncie Central	Zionsville	Westfield
	Yorktown		

Sectional 9	**Sectional 10**	**Sectional 11**	**Sectional 12**
Connersville	Indianapolis Arsenal Tech	Ben Davis	Avon
Greenfield-Central	**Indianapolis Cathedral**	**Decatur Central**	Brownsburg
Mt. Vernon (Fortville)	Lawrence Central	Perry Meridian	Mooresville
New Palestine	Lawrence North	Pike	Plainfield
Pendleton Heights	North Central (Indianapolis)	Roncalli	**Terre Haute North Vigo**
Richmond	Warren Central	Southport	Terre Haute South Vigo

Sectional 13	**Sectional 14**	**Sectional 15**	**Sectional 16**
Center Grove	Bloomington North	Bedford North Lawrence	Castle
Franklin Central	Bloomington South	Floyd Central	Evansville Central
Franklin Community	Columbus East	Jeffersonville	Evansville F.J. Reitz
Greenwood Community	Columbus North	Jennings County	**Evansville Harrison**
Martinsville	East Central	**New Albany**	Evansville North
Whiteland Community	**Shelbyville**	Providence	Jasper
		Seymour	

Class 3A

Sectional 17	**Sectional 18**	**Sectional 19**	**Sectional 20**
Gary West Side	Calumet	Culver Academies	Frankfort
Griffith	Hanover Central	Glenn	Maconaquah
Hammond	**Kankakee Valley**	Jimtown	Northwestern
Hammond Clark	Knox	Mishawaka Marian	Peru
Hammond Gavit	Twin Lakes	New Prairie	West Lafayette
Lighthouse CPA	Wheeler	**South Bend Saint Joseph**	**Western**
		South Bend Washington	

Sectional 21	**Sectional 22**	**Sectional 23**	**Sectional 24**
Fairfield	**Angola**	Bellmont	Blackford
Lakeland	Columbia City	Fort Wayne Luers	**Delta**
NorthWood	Fort Wayne Bishop Dwenger	Heritage	Hamilton Heights
Tippecanoe Valley	Garrett	Marion	Jay County
Wawasee	Leo	**Mississinewa**	Muncie Burris
West Noble	New Haven	Norwell	New Castle
			Wapahani

Sectional 25
Benton Central
Crawfordsville
Greencastle
Lebanon
North Montgomery
Southmont

Sectional 26
Brown County
Edgewood
Northview
South Vermillion
West Vigo
Owen Valley

Sectional 27
Brebeuf Jesuit Preparatory
Guerin Catholic
Indianapolis Bishop Chatard
Indianapolis Broad Ripple
Indianapolis Cardinal Ritter
Indianapolis Crispus Attucks
Indianapolis Northwest

Sectional 28
Beech Grove
Danville Community
Herron
Indian Creek
Indianapolis Emmerich Manual
Tri-West Hendricks

Sectional 29
Batesville
Franklin County
Greensburg
Lawrenceburg
Madison Consolidated
Rushville Consolidated
South Dearborn

Sectional 30
Brownstown Central
Charlestown
Corydon Central
North Harrison
Salem
Scottsburg
Silver Creek

Sectional 31
Pike Central
Princeton Community
Sullivan
Vincennes Lincoln
Washington

Sectional 32
Boonville
Evansville Bosse
Evansville Reitz Memorial
Gibson Southern
Heritage Hills
Mt. Vernon

Class 2A

Sectional 33
Andrean
Bowman Leadership Ac.
Gary Roosevelt
Hammond Bishop Noll
Lake Station Edison
River Forest
Whiting

Sectional 34
Boone Grove
Hebron
North Judson-San Pierre
North Newton
Rensselaer Central
Winamac Community

Sectional 35
Bremen
Central Noble
Churubusco
LaVille
Prairie Heights
Westview

Sectional 36
Adams Central
Bluffton
Eastside
Fort Wayne Blackhawk
Fort Wayne Canterbury
South Adams
Woodlan

Sectional 37
Cass
Manchester
North Miami
Rochester Community
Wabash
Whitko

Sectional 38
Carroll (Flora)
Clinton Prairie
Delphi
Fountain Central
Rossville
Seeger

Sectional 39
Eastbrook
Eastern (Greentown)
Madison-Grant
Oak Hill
Taylor
Tipton

Sectional 40
Alexandria Monroe
Elwood Community
Frankton
Lapel
Monroe Central
Sheridan

Sectional 41
Cambridge City Lincoln
Centerville
Hagerstown
Northeastern
Union County
Winchester Community

Sectional 42
Eastern Hancock
Indianapolis Howe Community
Irvington Preparatory Acad.
Knightstown
Shenandoah
Triton Central

Sectional 43
Heritage Christian
Indianapolis Arlington
Indianapolis G. Washington
Indianapolis Scecina Memorial
Indianapolis Shortridge
Park Tudor
Speedway

Sectional 44
Cascade
Cloverdale
Covenant Christian (Indpls.)
Monrovia
North Putnam
South Putnam
Western Boone

Sectional 45	Sectional 46	Sectional 47	Sectional 48
Austin	Christian Academy of IN	Eastern Greene	Evansville Mater Dei
Milan	Clarksville	Linton-Stockton	Forest Park
North Decatur	Crawford County	**Mitchell**	North Posey
South Ripley	Eastern (Pekin)	North Daviess	Perry Central
Southwestern (Hanover)	**Henryville**	North Knox	Southridge
Switzerland County	Paoli	South Knox	South Spencer
			Tell City

Class 1A

Sectional 49	Sectional 50	Sectional 51	Sectional 52
21st Century Charter School	Caston	Argos	Bethany Christian
Kouts	Covenant Christian (DeMotte)	**Culver Community**	Elkhart Christian Academy
Marquette Catholic	North White	LaCrosse	**Fremont**
Morgan Township	Pioneer	Oregon-Davis	Hamilton
Washington Township	**South Newton**	South Bend Career Academy	Lakeland Christian Academy
Westville	Tri-County	South Central (Union Mills)	Lakewood Park Christian
Hammond Academy	West Central	Triton	

Sectional 53	Sectional 54	Sectional 55	Sectional 56
Attica	Clinton Central	Anderson Preparatory Ac.	Blue River Valley
Covington	Frontier	**Cowan**	**Randolph Southern**
Faith Christian	**Lafayette Central Catholic**	Daleville	Seton Catholic
North Vermillion	Northfield	Liberty Christian	Tri
Riverton Parke	Southwood	Southern Wells	Union (Modoc)
Rockville	Tri-Central	Wes-Del	Union City
Turkey Run			

Sectional 57	Sectional 58	Sectional 59	Sectional 60
Bloomfield	Bethesda Christian	Central Christian Academy	**Hauser**
Clay City	**Indiana School for the Deaf**	Christel House Acad.	Jac-Cen-Del
Eminence	Indianapolis Metropolitan	Greenwood Christian Academy	Oldenburg Academy
North Central (Farmersburg)	International School of Indiana	Indianapolis Lighthouse South	Rising Sun
Shakamak	Tindley	Indianapolis Lutheran	South Decatur
White River Valley	Traders Point Christian Acad.	**Morristown**	Southwestern (Shelbyville)
	University	Providence Cristo Ray	Waldron

Sectional 61	Sectional 62	Sectional 63	Sectional 64
Borden	Crothersville	**Barr Reeve**	Cannelton
Lanesville	**Edinburgh**	Loogootee	Northeast Dubois
New Washington	Medora	Orleans	Springs Valley
Rock Creek Academy	Shawe Memorial	Shoals	**Tecumseh**
South Central (Elizabeth)	Trinity Lutheran	Vincennes Rivet	Wood Memorial
	West Washington	Washington Catholic	

Regionals-October 21

Class 4A

Regional 1	**Regional 2**	**Regional 3**	**Regional 4**
LaPorte	***Muncie Central***	***Greenfield-Central***	***Seymour***
Lowell	Fort Wayne Snider	Mt. Vernon (Fortville)	Martinsville
Valparaiso	Yorktown	Indpls. Cathedral	Shelbyville
South Bend Clay	McCutcheon	Decatur Central	New Albany
Warsaw Community	Noblesville	Terre Haute North	Evansville Harrison

Class 3A

Regional 5	**Regional 6**	**Regional 7**	**Regional 8**
Kankakee Valley	***Norwell***	***Danville***	***Corydon Central***
Hammond Gavit	West Noble	North Montgomery	Franklin County
Kankakee Valley	Angola	Edgewood	Charlestown
South Bend St. Joe	Mississinewa	Indpls. Ritter	Sullivan
Western	Delta	Indian Creek	Mt. Vernon (Posey)

Class 2A

Regional 9	**Regional 10**	**Regional 11**	**Regional 12**
LaVille	***Taylor***	***Triton Central***	***Mitchell***
River Forest	Rochester	Winchester	South Ripley
North Judson	Clinton Prairie	Eastern Hancock	Henryville
Central Noble	Madison-Grant	Heritage Christian	Mitchell
South Adams	Alexandria Monroe	Monrovia	Tell City

Class 1A

Regional 13	**Regional 14**	**Regional 15**	**Regional 16**
Culver Community	***Clinton Central***	***Morristown***	***Loogootee***
Washington Township	Attica	White River Valley	New Washington
South Newton	Lafayette Central Catholic	IN School for the Deaf	Edinburgh
Culver Community	Cowan	Morristown	Barr-Reeve
Fremont	Randolph Southern	Hauser	Tecumseh

Semi State-October 28

North
Plymouth
Frankfort

South
Columbus East
Jasper

State Finals-November 4
Worthen Arena, Ball State University, Muncie

A motion to approve the recommendations for the 2017-18 Volleyball Tournament Series was made by Richard Lance; seconded by Brian Strong; motion approved 19-0.

Approve 2017-18 Executive Committee Meeting Dates

Chairman-Elect Ed Gilliland proposed the following schedule for Executive Committee meeting dates during 2017-18:

- Tuesday, August 22, 2017
- Thursday, October 5, 2017
- Friday, November 3, 2017
- Thursday, December 14, 2017
- Thursday, January 11, 2018
- Friday, February 16, 2018
- Friday, March 23, 2018
- Monday, April 30, 2018
- Wednesday, June 20, 2018 & Thursday, June 21, 2018

A motion to approve the Executive Committee meeting dates was made by Brian Strong; seconded by Steve Cox; motion approved 19-0.

Approve 2017-18 Fall Area Principal Meeting Dates

Commissioner Bobby Cox proposed the following schedule to conduct the Fall Area Principals Meetings in September and October to discuss current programs and initiatives for the school year. All member school principals and athletic administrators are invited to attend. Additionally, member schools are encouraged to bring student leaders to this event as a student only session will be conducted to discuss leadership and sportsmanship.

District	Date	Time	Location
I	Tuesday, Sept. 12, 2017	9:30 am ET	Plymouth HS
I	Wednesday, Sept. 13, 2017	9:30 am CT	Merrillville HS
III	Monday, Sept. 18, 2017	9:30 am ET	North Daviess HS
III	Tuesday, Sept. 26, 2017	9:30 am ET	Jennings County HS
III	Wednesday, Sept. 27, 2017	9:30 am CT	Evansville Harrison HS
II	Monday, Oct. 2, 2017	9:30 am ET	Pendleton Heights HS
I	Tuesday, Oct. 3, 2017	9:30 am ET	Huntington North HS
II	Wednesday, Oct. 4, 2017	9:30 am ET	Arsenal Technical HS

A motion to approve the Fall Area Principals Meetings schedule was made by Richard Lance; seconded by Stacy Adams; motion approved 19-0.

2017-18 IHSAA Executive Committee Appointments

Chairman-Elect Ed Gilliland distributed the 2017-18 committee appointments to Executive Committee members:

- Awards & Public Relations Committee – Chairperson Stacy Adams; David Amor; Jim Brown; Victor Bush; Steve Cox; Charlie Martin; Bobby Cox, Staff Liaison; Chris Kaufman, Staff Liaison.

- Investment Committee – Chairperson Mike Broughton; Stacy Adams; Steve Cox; Brian Strong; Mike Whitten; Rae Woolpy; Bobby Cox, Staff Liaison; Paul Neidig, Staff Liaison.

- Personnel Committee – Chairperson Patti McCormack; Mike Broughton, Nathan Dean; Don Gandy; Tim Grove; Brian Strong; Rae Woolpy; Dave Worland; Bobby Cox, Staff Liaison.

- Student Advisory Committee – Chairperson Jim Brown; Jeff Doyle; Charlie Martin; Matt Martin; Patti McCormack; Dave Worland; Robert Faulkens, Staff Liaison; Kerrie Schludecker, Staff Liaison.

- Technology Committee – Chairperson Tim Grove; David Amor; Victor Bush; Nathan Dean; Jeff Doyle; Don Gandy; Matt Martin; Mike Whitten; Luke Morehead, Staff Liaison; Sandra Walter, Staff Liaison.

A motion to approve the Executive Committee appointments was made by Dave Worland; seconded by Brian Strong; motion approved 19-0.

Approve Adjustments in 2017-18 Tournament Finances

Assistant Commissioner Kerrie Schludecker presented recommended changes in for tournament finances in selected sports:

Tournament Admissions

- *Cross country state finals admission will increase from $8 to $10.*
- *The $8 session ticket is eliminated in boys and girls soccer semi-states with a $10 season ticket remaining in place.*
- *State swimming season ticket will increase from $12 to $15 and the reserved seat season ticket from $15 to $18.*
- *A $10 regional season ticket in volleyball is to be added while the $10 season ticket at semi-state will be eliminated. The volleyball state finals ticket will increase from $10 to $12.*

Allowances for Center Schools and Participating Schools

- *Boys and girls soccer will be combined and the sectional center school allowance will become $125 and the regional center school $100.*
- *Unified Track sectional and regional center schools allowance will each become $100.*
- *Volleyball regional center school will increase to $200 and the semi-state center school will decrease to $150.*
- *Wrestling semi-state center schools will increase to $400.*

Tournament Directors Stipends

- *The cross country tournament directors' stipend at each level will be set at $100 at the sectional, $100 at the regional, $200 at the semi-state, and $300 at the state finals.*
- *The soccer regional director stipend will become $100 and the soccer state director will increase to $300 and the assistant to $100.*
- *Unified Track regional director stipend will become $75.*
- *Volleyball regional director stipend should increase $125.*

Tournament Officials Stipends

- *Baseball and softball stipends will increase at the sectional to $55 per game and the state level to $75 per game.*
- *Football will be raised to $65 at the sectional and $100 at the state finals.*
- *In swimming, the sectional starter will increase to $120 and assistant starter to $95. The state finals assistant will increase to $100.*
- *The tennis sectional, regionals and semi-states will have a $55 per session fee if hired and must be approved by IHSAA.*
- *Unified Track and Field will have a $70 per starter and $55 per assistant across the board at the sectionals, regionals and state finals.*

State Medals Distribution

None.

After discussion, a motion to approve the recommendations was made by Jim Brown; seconded by Brian Strong; motion approved 19-0.

Approve 2017-18 Contracts & Salaries for IHSAA Staff
Chairman-Elect Ed Gilliland presented a salary and benefits proposal covering all staff for 2017-18.

A motion to approve the salary and benefits package for IHSAA staff was made by Nathan Dean; seconded by Steve Cox; motion approved 19-0.

Approve 2017-18 Budget
Commissioner Cox submitted a proposed budget for 2017-18 which doesn't include some of the spring sports tournament reports since some just concluded.

A motion to approve the proposed budget was made by Jim Brown; seconded by Ed Gilliland; motion approved 19-0.

Resignation of Paul Neidig from the Board of Directors
Paul Neidig submitted his resignation from the IHSAA Board of Directors after 13 years effective June 30, 2017. He will assume his new position as Assistant Commissioner on July 1, 2017.

A motion to approve his resignation, with regret and congratulations, was made by Tim Grove; seconded by Patti McCormack; motion approved 19-0.

Status of Catastrophic, General Liability and Excess Liability Insurance Policies for 2017-18
Assistant Commissioner Faulkens presented a report on the insurance policies that will be in effect for 2017-18.

Transfers
Assistant Commissioner Phil Gardner reported on the transfers that have been ruled on for the 2016-17 school year including the following actions as of June 1, 2017 and, for comparison, the numbers for this time a year ago.

	2016-17	Percent	2015-16	Percent
Full Eligibility	3,666	82.96%	3,874	84.36%
Limited Eligibility	366	8.28%	301	6.55%
Temporarily Ineligible	363	8.21%	394	8.58%
Ineligible	24	0.54%	23	0.50%
Total	4,419		4,592	

Sportsmanship
Assistant Commissioner Walter updated the Executive Committee on the unsporting behavior reports that have been submitted for this school year as of June 12, 2017 and, for comparison, the numbers for this time a year ago. Final tabulations will be made following the compilation of schools attending the IHSAA Student Leadership Conference.

	2016-17	2015-16
Unsporting Reports Filed	3,200	3,370
Total Ejections	423	453
Ejections (Coaches)	64	74
Ejections (Players)	346	364
Ejections (Fans)	13	14
Ejections (Administration)	0	1

IHSAA Foundation Report
Commissioner Bobby Cox provided a report on the IHSAA Foundation after meeting with its Board of Director last weekend as well as a search for a new president following Steve Helmich's resignation. He reminded everyone of the Second Annual IHSAA Foundation Golf Outing set for Saturday, August 12, 2017 at Prairie View Golf Course in Carmel.

Litigation
Attorney Robert Baker updated the Executive Committee on the current status of pending litigation against the Association.

Penalties Assessed
The following penalties were assessed for various violations of the IHSAA By-Laws:

Attica HS – Rule 51-4 ((*Junior varsity baseball player exceeded the number of allowable pitches in a day)*

1. The Attica High School baseball program is issued a warning. This warning is official notice that an illegal act has occurred, is a matter of record, and shall not be repeated.
2. JV Coach Nick Burris is reprimanded for allowing this violation to occur. The revisions of Rule 51-4 have been written to promote the health and safety of student athletes in the sport of baseball along with creating a level field of competition between schools.
3. As per Rule 3-9.5a of the IHSAA by-laws, the game in which the limitation was surpassed shall be forfeited if Attica was victorious. Attica shall notify their opponent of this violation.
4. The suspension of the student athlete provided by the school is supported by the IHSAA in this matter.

Austin HS – Rule 19-3 *(Softball player participated in multiple contests without an approved transfer report on file)*

1. The Austin High School softball program is issued a warning. This warning is official notice that a rule violation has occurred, is a matter of record, and shall not be repeated.
2. The student is declared ineligible until a completed transfer report is submitted and ruled upon.
3. The games the ineligible student participated in shall be forfeited if Austin was victorious. The opposing schools shall be notified of this violation.

Blue River Valley HS – Rule 19-3 *(Softball player participated in multiple contests without an approved transfer report on file)*

1. The Blue River Valley High School softball program is issued a warning. This warning is official notice that a rule violation has occurred, is a matter of record, and shall not be repeated.
2. The student is declared ineligible until a completed transfer report is submitted and ruled upon.
3. The games the ineligible student participated in shall be forfeited if Blue River Valley was victorious. The opposing schools shall be notified of this violation.

Danville Community HS – Rule 51-4 (*Junior varsity baseball player exceeded the number of allowable pitches in a day)*

1. The Danville Community High School baseball program is issued a warning. This warning is official notice that an illegal act has occurred, is a matter of record, and shall not be repeated.
2. Assistant Coach Chris Marckel is reprimanded for allowing this violation to occur. The revisions of Rule 51-4 have been written to promote the health and safety of student athletes in the sport of baseball along with creating a level field of competition between schools.
3. As per Rule 3-9.5a of the IHSAA by-laws, the game in which the limitation was surpassed shall be forfeited if Danville Community was victorious. Danville Community shall notify their opponent of this violation.
4. Student athlete Kyle Brabec shall be limited to no more than the maximum number of pitches available after his mandatory three-day rest period minus the pitches thrown beyond the limitation in this violation. Further violations of this nature shall be handled in a more severe manner.

Faith Christian HS – Rule 19-3 *(Baseball player participated in multiple contests without an approved transfer report on file)*

1. The Faith Christian School baseball program is issued a warning. This warning is official notice that a rule violation has occurred, is a matter of record, and shall not be repeated.
2. The student is declared ineligible until a completed transfer report is submitted and ruled upon.
3. The games the ineligible student participated in shall be forfeited if Faith Christian was victorious. The opposing schools shall be notified of this violation.

Faith Christian HS – Rule 19-3 *(Softball player participated in multiple contests without an approved transfer report on file)*

1. The Faith Christian School softball program is issued a warning. This warning is official notice that a rule violation has occurred, is a matter of record, and shall not be repeated.
2. The student is declared ineligible until a completed transfer report is submitted and ruled upon.
3. The games the ineligible student participated in shall be forfeited if Faith Christian was victorious. The opposing schools shall be notified of this violation.

Hammond Bishop Noll HS – Rule 15-1.2a *(Softball player participated in a non-school sponsored softball contest)*

1. The Hammond Bishop Noll High School softball program is issued a warning. This warning is official notice that an illegal act has occurred, is a matter of record, and shall not be repeated.
2. The student shall be suspended for the championship game of Sectional 33 between Hammond Bishop Noll and Whiting unless the student sat out for a previously contested sectional game.

Hammond Gavit HS – Policy Manual *(Softball team withdrew from tournament series after the drawing)*

1. The Hammond Gavit High School softball program is placed on probation for the 2017-2018 season. This probation is a severe type of warning. It is official notice that serious violations have occurred, are a matter of record and future, similar incidents will not be tolerated.
2. As per IHSAA policy, Hammond Gavit High School shall remit $200.00 as a financial penalty in this matter.

Indianapolis Arlington HS – Policy Manual *(Baseball team withdrew from tournament series after the drawing)*

1. The Indianapolis Arlington High School baseball program is placed on probation for the 2017-2018 season. This probation is a severe type of warning. It is official notice that serious violations have occurred, are a matter of record and future, similar incidents will not be tolerated.
2. As per IHSAA policy, Indianapolis Arlington High School shall remit $200.00 as a financial penalty in this matter.

Indianapolis Arsenal Technical HS – Policy Manual *(Baseball team withdrew from tournament series after the drawing)*

1. The Indianapolis Arsenal Technical High School baseball program is placed on probation for the 2017-2018 season. This probation is a severe type of warning. It is official notice that serious violations have occurred, are a matter of record and future, similar incidents will not be tolerated.
2. As per IHSAA policy, Indianapolis Arsenal Technical High School shall remit $200.00 as a financial penalty in this matter.

Indianapolis George Washington HS – Rule 19-3 *(Baseball player participated in multiple contests without an approved transfer report on file)*

1. The Indianapolis George Washington Community High School baseball program is issued a warning. This warning is official notice that a rule violation has occurred, is a matter of record, and shall not be repeated.
2. The student is declared ineligible until a completed transfer report is submitted and ruled upon.
3. The games the ineligible student participated in shall be forfeited if Indpls. Washington was victorious. The opposing schools shall be notified of this violation.

LaCrosse HS – Rule 19-3 *(Baseball player participated in multiple contests without an approved transfer report on file)*

1. The LaCrosse High School baseball program is issued a warning. This warning is official notice that a rule violation has occurred, is a matter of record, and shall not be repeated.
2. The student is declared ineligible until a completed transfer report is submitted and ruled upon.

3. The games the ineligible student participated in shall be forfeited if LaCrosse was victorious. The opposing schools shall be notified of this violation.

Marquette Catholic HS – Rule 19-3 *(Softball player participated in multiple contests without an approved transfer report on file)*

1. The Marquette Catholic High School softball program is issued a warning. This warning is official notice that a rule violation has occurred, is a matter of record, and shall not be repeated.
2. The student is declared ineligible until a completed transfer report is submitted and ruled upon.
3. The games the ineligible student participated in shall be forfeited if Marquette Catholic was victorious. The opposing schools shall be notified of this violation.

Marquette Catholic HS – Rule 20-1 a b c *(Girls' soccer team assistant coach exercised undue influence on a middle school student to attend the school and participate on the soccer team – PROBATION)*

1. The Marquette Catholic High School girls' soccer program is placed on probation for the 2017-18 school year. Probation is a serious warning that a violation has occurred, is a matter of record, and shall not be repeated.
2. The IHSAA accepts the actions of the Marquette Catholic High School administration in this matter as acceptable. Further violations in this area by the girls' soccer program shall be handled in a more severe manner.
3. The contests where Nicole Melton was a participant during the 2016-17 season shall be forfeited if Marquette Catholic was victorious. Each opposing school shall be noticed of this violation.

Mooresville HS – Rule 18-1 *(Girls' track and field athlete participated in multiple meets while academically ineligible)*

1. The Mooresville High School girls' track and field program is issued a warning. This warning is official notice that a rule violation has occurred, is a matter of record, and shall not be repeated.
2. The student athlete involved in this violation shall be declared ineligible immediately. The student may gain academic eligibility at the next certification date of the school.
3. The meets that the ineligible student participated in shall be rescored to reflect the removal of any points scored by the ineligible student. The opposing schools shall be notified of this violation.

New Haven HS – Rule 51-4 (*Junior varsity baseball player exceeded the number of allowable pitches in a day)*

1. The New Haven High School baseball program is issued a warning. This warning is official notice that an illegal act has occurred, is a matter of record, and shall not be repeated.
2. Head Coach Dave Bischoff is reprimanded for allowing this violation to occur. The revisions of Rule 51-4 have been written to promote the health and safety of student athletes in the sport of baseball along with creating a level field of competition between schools.
3. As per Rule 3-9.5a of the IHSAA by-laws, the game in which the limitation was surpassed shall be forfeited if New Haven was victorious. New Haven shall notify their opponent of this violation.
4. Student athlete Chase Geier shall be limited to no more than the maximum number of pitches available after his mandatory three-day rest period minus the pitches thrown beyond the limitation in this violation. Further violations of this nature shall be handled in a more severe manner.

North Central (Farmersburg) HS – Rule 19-3 *(Baseball player participated in multiple contests without an approved transfer report on file)*

1. The North Central High School baseball program is issued a warning. This warning is official notice that a rule violation has occurred, is a matter of record, and shall not be repeated.
2. The student is declared ineligible until a completed transfer report is submitted and ruled upon.
3. The games the ineligible student participated in shall be forfeited if North Central was victorious. The opposing schools shall be notified of this violation.

North Miami HS – Rule 19-3 *(Softball player participated in multiple contests without an approved foreign exchange student eligibility request on file)*

1. The North Miami High School softball program is issued a warning. This warning is official notice that a rule violation has occurred, is a matter of record, and shall not be repeated.

2. The student is declared ineligible until a completed foreign exchange student eligibility report is submitted and ruled upon.
3. The games the ineligible student participated in shall be forfeited if North Miami was victorious. The opposing schools shall be notified of this violation.

Northeastern HS – Rule 19-3 *(Girls' track and field athlete participated in multiple meets without an approved foreign exchange report on file)*

1. The Northeastern High School girls' track and field program is issued a warning. This warning is official notice that a rule violation has occurred, is a matter of record, and shall not be repeated.
2. The student is declared ineligible until a completed foreign exchange student eligibility report is submitted and ruled upon.
3. The meet that the ineligible student participated in shall be rescored to reflect the removal of any points scored by the ineligible student. The opposing schools shall be notified of this violation.

Penn HS – Rule 15-2.2 *(Four girls were rostered on the same non-school sponsored volleyball team)*

1. The Penn High School volleyball program is issued a warning. This warning is official notice that an illegal act has occurred, is a matter of record, and shall not be repeated.
2. Head Coach Sarah Hendricks is reprimanded for allowing this violation to occur. It is the responsibility of the head coach to insure all student athletes follow Association rules.

Salem HS – Rule 19-3 *(Girls' track and field athlete participated in multiple meets without an approved transfer report on file)*

1. The Salem High School girls' track and field program is issued a warning. This warning is official notice that a rule violation has occurred, is a matter of record, and shall not be repeated.
2. The student is declared ineligible until a completed transfer report is submitted and ruled upon.
3. The meets that the ineligible student participated in shall be rescored to reflect the removal of any points scored by the ineligible student. The opposing schools shall be notified of this violation.

Southport HS – Rule 4-1 *(Two girls' tennis players participated in multiple matches in violation of Rule 4)*

1. The Southport High School girls' tennis program is issued a warning. This warning is official notice that an illegal act has occurred, is a matter of record, and shall not be repeated.
2. The student athletes involved in this violation shall be suspended and declared ineligible for further competition.
3. In accordance with Rule 3-9, the contests in which the ineligible athletes participated in shall be rescored to remove any scoring achieved by the ineligible athletes and the team scores refigured. The participating schools involved with this violation shall be notified.

Items for Discussion

1. Spring Area Principal Meeting Dates for 2017-18 – Bobby Cox
   - District II Tuesday, April 10, 2018 9:30 am ET Pendleton Heights HS
   - District I Wednesday, April 11, 2018 9:30 am ET Fort Wayne Snider HS
   - District III Tuesday, April 17, 2018 9:30 am ET Vincennes Lincoln HS
   - District II Wednesday, April 18, 2018 9:30 am ET Plainfield HS
   - District III Tuesday, April 24, 2018 9:30 am ET Jennings County HS
   - District I Thursday, April 26, 2018 9:30 am CT Merrillville HS
2. Communications
3. Congratulations
4. For the Good of the Order

A motion to adjourn was made by Don Gandy; seconded by Jim Brown; the motion was approved 19-0.

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Debb Stevens, Chairwoman

_____

Bobby Cox, Commissioner

U.S. Citizenship and Immigration Services

\ afm \ Adjudicator's Field Manual \ Chapter 10 An Overview of the Adjudication Process. \ 10.22 Change of Gender Designation on Documents Issued by USCIS

Previous Document | Next Document

10.22 Change of Gender Designation on Documents Issued by USCIS (Added 4/10/2012; PM-602-0061; AD12-02; PM-602-0141)

USCIS issues a variety of documents that show identity and immigration status in the United States. These include, but are not limited to, Employment Authorization Documents, Refugee Travel Documents, Permanent Resident Cards, and Certificates of Citizenship or Naturalization. Individuals may request a change in the gender reflected on a USCIS-issued document using the standard USCIS form for requesting the desired document. USCIS will issue an initial or amended document reflecting the changed gender designation if the individual presents one of the following forms of evidence in support of the change in gender designation along with meeting all other requirements for the requested document:

- A court order granting change of sex or gender;
- A government-issued document reflecting the requested gender designation. Acceptable government-issued documents include an amended birth certificate, a passport, a driver's license, or other official document showing identity issued by the U.S. Government, a state or local government in the United States, or a foreign government; or
- A letter from a licensed health care professional certifying that the requested gender designation is consistent with the individual's gender identity. For the purposes of this subchapter, a licensed health care professional includes licensed counselors, nurse practitioners, physicians (Medical Doctors or Doctors of Osteopathy), physician assistants, psychologists, social workers, and therapists. The health care certification letter must include the following information:
  - The health care professional's full name, address, and telephone number;
  - The health care professional's license number and the issuing state, country, or other jurisdiction of the professional license;
  - Language stating that the health care professional has treated or evaluated the individual in relation to the individual's gender identity[1]; and
  - The health care professional's assessment of the individual's gender identity.

Sample health care certification language can be found in Appendix 10-22, Change of Gender Designation on Documents Issued by USCIS.

USCIS may request additional evidence of the individual's gender identity, as necessary to verify the requested change in gender designation. As in all adjudications, if an officer finds significant substantive discrepancies, has reason to question the accuracy or authenticity of documents submitted, or finds other indicators of fraud, the case may be referred to the USCIS Fraud Detection and National Security Directorate (FDNS) in accordance with current national and local policies.

If the individual is also requesting that a name change be reflected on the document to be issued by USCIS, evidence that the name change was completed according to the relevant state or foreign law must also be submitted.

EXHIBIT G

USCIS-issued documents that display a gender or sex identifier are limited to indicating only female or male. Consequently, requests for USCIS-issued documents reflecting a change of gender designation must indicate either female or male as the new gender.

NOTES

[1] Proof of sex reassignment surgery or any other specific medical treatment is not required to issue the requested document in the changed gender.

\ afm \ Adjudicator's Field Manual \ Chapter 10 An Overview of the Adjudications Process. \ 10.22 Change of Gender Designation on Documents Issued by USCIS

Previous Document | Next Document

U.S. Department of Justice
Federal Bureau of Prisons

CHANGE NOTICE
OPI: RSD/WSP
NUMBER: 5200.04 CN-1
DATE: May 11, 2018

Transgender Offender Manual

Approved: Mark S. Inch
Director, Federal Bureau of Prisons

This Change Notice (CN) implements the following change to Program Statement 5200.04, **Transgender Offender Manual**, dated January 18, 2017. The purpose of the Change Notice is to ensure that the Transgender Executive Council (TEC) considers issues related to prison management and security in determining appropriate housing of transgender inmates, including risks posed to staff, other inmates, and members of the public. The clarifications to policy will establish appropriate expectations for the inmate population concerning designations.

The changes are marked with a highlight and inserted into the policy. Deleted text is struck through. In addition, the branch name has been changed from Female Offender Branch to Women and Special Populations Branch.

1. **PURPOSE AND SCOPE**

To ensure the Bureau of Prisons (Bureau) properly identifies, tracks, and provides services to the transgender population, consistent with maintaining security and good order in Federal prisons.

4. **STAFF TRAINING**

The **Women and Special Populations Branch** will be responsible for developing training materials and current information on the management of transgender inmates. Training will include information concerning best practices for maintaining the safety of transgender inmates, while also ensuring security and good order in Federal prisons and the safety of staff, inmates, and the public. This information will be made available to staff on the Women and Special Populations Branch Sallyport page.

5. **INITIAL DESIGNATIONS**

The TEC will consider factors including, but not limited to, an inmate's security level, criminal and disciplinary history, current gender expression, medical and mental health needs/information, vulnerability to sexual victimization, and likelihood of perpetrating abuse. The TEC may also consider facility-specific factors, including inmate populations, staffing patterns, and physical layouts (e.g., types of showers available). ~~The TEC will recommend housing by gender identity when appropriate.~~

In deciding the facility assignment for a transgender or intersex inmate, the TEC should make the following assessments on a case-by-case basis:

- The TEC will use biological sex as the initial determination for designation;
- The TEC will consider the health and safety of the transgender inmate, exploring appropriate options available to assist with mitigating risk to the transgender offender, to include but not limited to cell and/or unit assignments, application of management variables, programming missions of the facility, etc.;
- The TEC will consider factors specific to the transgender inmate, such as behavioral history, overall demeanor, and likely interactions with other inmates; and
- The TEC will consider whether placement would threaten the management and security of the institution and/or pose a risk to other inmates in the institution (e.g., considering inmates with histories of trauma, privacy concerns, etc.).

The designation to a facility of the inmate's identified gender would be appropriate only in rare cases after consideration of all of the above factors and where there has been significant progress towards transition as demonstrated by medical and mental health history.

It will be noted in SENTRY designation notes that the TEC reviewed the inmate for appropriate institution designation.

7. **HOUSING AND PROGRAMMING ASSIGNMENTS**

In order for an inmate to be considered for transfer to another institution of the same sex as the inmate's current facility ~~location, including a facility housing individuals of the inmate's identified gender~~, the Warden should consult with the TEC prior to submitting a designation request to the DSCC, but this is not required.

In addition, the Warden may make a recommendation to the TEC to transfer a transgender or intersex inmate based on an inmate's identified gender.

In considering such recommendations, the TEC will apply all criteria of Section 5, above, and make the following assessments concerning the recommendation:

- The TEC will use biological sex as the initial determination for designation;
- The TEC will consider the health and safety of the transgender inmate, exploring appropriate options available to assist with mitigating risk to the transgender offender, to include but not limited to cell and/or unit assignments, application of management variables, programming missions of the facility, re-designation to another facility of the same sex, etc.;
- The TEC will also consider factors specific to the transgender inmate, such as behavioral history, overall demeanor, program participation, and likely interactions with other inmates; and
- The TEC will consider whether placement would threaten the management and security of the institution and/or pose a risk to other inmates in the institution (e.g., considering inmates with histories of trauma, privacy concerns, etc.).

The designation to a facility of the inmate's identified gender would be appropriate only in rare cases after consideration of all of the above factors and where there has been significant progress towards transition as demonstrated by medical and mental health history, as well as positive institution adjustments.

It will be noted in SENTRY designation notes that the TEC reviewed the inmate for appropriate institution designation.

9. **HORMONE AND NECESSARY MEDICAL TREATMENT**

Hormone or other necessary medical treatment may be provided after an individualized assessment of the requested inmate by institution medical staff. Medical staff should request consultation from Psychology Services regarding the mental health benefits of hormone or other necessary medical treatment. If appropriate for the inmate, hormone treatment will be provided in accordance with the Program Statement **Patient Care** and relevant clinical guidance. Questions concerning hormone treatment may be referred to the TCCT.

U.S. Department of Justice
Federal Bureau of Prisons

P R O G R A M S T A T E M E N T
OPI: RSD/FOB
NUMBER: 5200.04
DATE: January 18, 2017

Transgender Offender Manual

/s/
Approved: Thomas R. Kane
Acting Director, Federal Bureau of Prisons

1. **PURPOSE AND SCOPE**

To ensure the Bureau of Prisons (Bureau) properly identifies, tracks, and provides services to the transgender population, consistent with maintaining security and good order in Federal prisons.

a. **Program Objectives**. Expected results of this program are:

- This policy is meant to provide guidance to staff in dealing with the unique issues that arise when working with transgender inmates.
- Institutions ensure transgender inmates can access programs and services that meet their needs as appropriate, and prepare them to return to the community.
- Sufficient resources will be allocated to deliver appropriate services to transgender inmates.
- Staff will be offered training, enabling them to work effectively with transgender inmates.
- To support staff's understanding of the increased risk of suicide, mental health issues and victimization of transgender inmates.

b. **Institution Supplement**. None required. Should local facilities make any changes outside changes required in national policy or establish any additional local procedures to implement national policy, the local Union may invoke to negotiate procedures or appropriate arrangements.

2. **DEFINITIONS**

Gender – a construct used to classify a person as male, female, both, or neither. Gender encompasses aspects of social identity, psychological identity, and human behavior.

Gender identity – a person's sense of their own gender, which is communicated to others by their gender expression.

Gender expression – includes mannerisms, clothing, hair style, and choice of activities.

Gender nonconforming – a person whose appearance or manner does not conform to traditional societal gender expectations.

Transgender – the state of one's gender identity not matching one's biological sex. For the purposes of this policy, a transgender inmate is one who has met with a Bureau of Prisons psychologist and signed the form indicating consent to be identified within the agency as transgender. This step allows for accommodations to be considered.

Cisgender – the state of one's gender identity matching one's biological sex.

Sexual orientation – the direction of one's sexual interest towards members of the same, opposite, or both genders (e.g., heterosexual, homosexual, bisexual, asexual). Sexual orientation and gender identity are not related.

Gender Dysphoria (GD) – a mental health diagnosis currently defined by DSM-5 as, "A strong and persistent cross-gender identification. It is manifested by a stated desire to be the opposite sex and persistent discomfort with his or her biologically assigned sex." Not all transgender inmates will have a diagnosis of GD, and a diagnosis of GD is not required for an individual to be provided services.

Intersex – a person whose sexual or reproductive anatomy or chromosomal pattern does not seem to fit typical biological definitions of male or female. Not all intersex people identify as transgender; unless otherwise specified, this policy does not apply to intersex people who do not identify as transgender.

Transition – measures that change one's gender expression or body to better reflect a person's gender identity.

3. **STAFF RESPONSIBILITIES**

The following Bureau components are responsible for ensuring consistent establishment of the programs, services, and resource allocations necessary for transgender offenders.

a. **Central Office**

(1) The **Women and Special Populations Branch** is the agency's primary source and point of contact on classification, management, and intervention programs and practices for transgender inmates in Bureau custody. The Branch is responsible for the following functions as they relate to transgender inmates:

- Engaging stakeholders, including serving as the primary point of contact on issues affecting transgender inmates with judges, political figures, and advocacy groups.
- Ensuring the Bureau offers appropriate services to transgender inmates.
- Preparing budgetary requests to deliver national and pilot programs or services affecting transgender inmates.
- Providing guidance and direction to Regional staff and institution leadership on transgender issues.
- Developing and implementing staff training on transgender issues.
- Building a research-based foundation for the Bureau's work with transgender inmates.
- Presenting at internal and external conferences/events regarding the agency's transgender inmates' practices.
- Developing and monitoring monthly reports on the transgender population and institutional programs.
- Issuing an annual report on the state of transgender offenders in the Bureau that will be made available to all staff and stakeholders.
- Advising agency leadership on transgender inmate needs.
- Conducting an annual survey of transgender inmates in the Bureau and sharing results with internal and external stakeholders.
- Providing national oversight of pilot programs and initiatives serving transgender offenders.

(2) The **Health Services Division** oversees all medical and psychiatric activity as it applies to transgender inmates. Guidance on the most current research-driven clinical medical and psychiatric care of transgender inmates will be provided by the Medical Director.

The Health Services Division also has oversight of a Transgender Clinical Care Team (TCCT). This team will be comprised of Physicians, Pharmacists, and Psychiatrists. Social Workers, Psychologists, and other clinical providers can also be included when appropriate. The TCCT will offer advice and guidance to health services staff on the medical treatment of transgender inmates and/or inmates with GD. Medical staff can raise issues to the TCCT through the Health Services Division.

(3) The **Psychology Services Branch** oversees all psychological mental health programs and services as they apply to transgender inmates, to include providing advice and guidance on

identification and evaluation of transgender inmates, and making recommendations for treatment needs of transgender inmates and/or inmates with GD.

(4) **Central Office Branches/Divisions** of Correctional Services, Psychology Services, Education, Correctional Programs, Reentry Affairs, Residential Reentry Management, Health Services, Health Programs, Social Work, Office of General Counsel, and Trust Fund meet annually with the Women and Special Populations Branch to discuss transgender population needs and evaluate current gender-responsive services. The National Union and the Central Office LGBT Special Emphasis Program Manager will be invited to attend these meetings.

(5) The **Transgender Executive Council (TEC)** will consist of staff members from the Health Services Division, the Women and Special Populations Branch, Psychology Services, the Correctional Programs Division, the Designation and Sentence Computation Center (DSCC), and the Office of General Counsel. The TEC will meet a minimum of quarterly to offer advice and guidance on unique measures related to treatment and management needs of transgender inmates and/or inmates with GD, including designation issues. Institution staff and DSCC staff may raise issues on specific inmates to the TEC through the Women and Special Populations Branch. The National PREA Coordinator is consulted as needed.

b. **Regional Offices**

- Provide oversight to institutions regarding services and other relevant trends managing transgender inmates.
- Assign transgender responsibilities to the Regional Female Offender/Transgender Coordinator Collateral Duty Assignment. This individual meets quarterly with the Women and Special Populations Branch to discuss staffing and programming needs.

c. **Institutions**

The institution CEO will establish a multi-disciplinary approach to the management of transgender inmates; specifically:

- Ensure transgender inmates have access to services.
- Enter tracking information for self-identified transgender inmates by updating SENTRY and other databases (e.g., PDS), as appropriate.
- Provide appropriate reentry resources that may be specific to the population.
- Advise the Local Union of transgender inmate management issues, as appropriate.

4. **STAFF TRAINING**

Staff will be provided specialized training in working with unique issues when managing transgender inmates, with refresher training at annual training. Institutions housing known transgender inmates should provide additional training, if needed.

The Women and Special Populations Branch will be responsible for developing training materials and current information on the management of transgender inmates. Training will include information concerning best practices for maintaining the safety of transgender inmates, while also ensuring security and good order in Federal prisons and the safety of staff, inmates, and the public. This information will be made available to staff on the Women and Special Populations Branch Sallyport page.

In addition, the Prison Rape Elimination Act (PREA) regulations incorporated into the BOP Program Statement **Sexually Abusive Behavior Prevention and Intervention Program** have training requirements concerning pat searches and communication skills for transgender inmates. See 28 C.F.R. § 115.15(f) and 115.31 (a) (9). Please refer to this Program Statement regarding implementation of those training requirements.

Staff will be provided adequate time to complete these trainings during duty hours.

5. **INITIAL DESIGNATIONS**

The PREA regulations, incorporated into the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program**, state in section 28 C.F.R. § 115.42 (c):

> **"In deciding whether to assign a transgender or intersex inmate to a facility for male or female inmates…the agency shall consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems."**

Upon receipt of information from a Pre-Sentence Report, court order, U.S. Attorney's Office, defense counsel, the offender, or other source that an individual entering BOP custody is transgender, designations staff will refer the matter to the TEC for advice and guidance on designation.

Institution staff managing pretrial or holdover offenders may also refer cases to the TEC for review. Any TEC recommendations concerning pretrial inmates will be coordinated with the appropriate United States Marshal's Office.

The TEC will consider factors including, but not limited to, an inmate's security level, criminal and disciplinary history, current gender expression, medical and mental health needs/information, vulnerability to sexual victimization, and likelihood of perpetrating abuse. The TEC may also consider facility-specific factors, including inmate populations, staffing patterns, and physical layouts (e.g., types of showers available). ~~The TEC will recommend housing by gender identity when appropriate.~~

In deciding the facility assignment for a transgender or intersex inmate, the TEC should make the following assessments on a case-by-case basis:

- The TEC will use biological sex as the initial determination for designation;
- The TEC will consider the health and safety of the transgender inmate, exploring appropriate options available to assist with mitigating risk to the transgender offender, to include but not limited to cell and/or unit assignments, application of management variables, programming missions of the facility, etc.;
- The TEC will consider factors specific to the transgender inmate, such as behavioral history, overall demeanor, and likely interactions with other inmates; and
- The TEC will consider whether placement would threaten the management and security of the institution and/or pose a risk to other inmates in the institution (e.g., considering inmates with histories of trauma, privacy concerns, etc.).

The designation to a facility of the inmate's identified gender would be appropriate only in rare cases after consideration of all of the above factors and where there has been significant progress towards transition as demonstrated by medical and mental health history.

It will be noted in SENTRY designation notes that the TEC reviewed the inmate for appropriate institution designation.

6. INTAKE SCREENING

The PREA regulations in 28 C.F.R. part 115, Subpart A, incorporated into the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program** and the Program Statement **Intake Screening,** address intake screening. Screening of transgender inmates will be conducted in accordance with these policies and all other applicable policies and procedures.

7. HOUSING AND PROGRAMMING ASSIGNMENTS

During Initial classification and Program Reviews, Unit Management staff will twice-yearly review the inmate(s) current housing unit status and programming available for transgender inmates; this review will be documented by Unit Management.

The reviews will consider on a case-by-case basis that the inmate placement does not jeopardize the inmate's health and safety and does not present management or security concerns.

In making housing unit and programming assignments, a transgender or intersex inmate's own views with respect to his/her own safety must be given serious consideration.

Transgender inmates shall be given the opportunity to shower separate from other inmates.

The agency shall not place transgender or intersex inmates in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility, unit, or wing established in connection with a consent decree , legal settlement, or legal judgment for the purpose of protecting such inmates.

In order for an inmate to be considered for transfer to another institution of the same sex as the inmate's current facility ~~location, including a facility housing individuals of the inmate's identified gender~~, the Warden should consult with the TEC prior to submitting a designation request to the DSCC, but this is not required.

In addition, the Warden may make a recommendation to the TEC to transfer a transgender or intersex inmate based on an inmate's identified gender.

In considering such recommendations, the TEC will apply all criteria of Section 5, above, and make the following assessments concerning the recommendation:

- The TEC will use biological sex as the initial determination for designation;
- The TEC will consider the health and safety of the transgender inmate, exploring appropriate options available to assist with mitigating risk to the transgender offender, to include but not limited to cell and/or unit assignments, application of management variables, programming missions of the facility, re-designation to another facility of the same sex, etc.;
- The TEC will also consider factors specific to the transgender inmate, such as behavioral history, overall demeanor, program participation, and likely interactions with other inmates; and
- The TEC will consider whether placement would threaten the management and security of the institution and/or pose a risk to other inmates in the institution (e.g., considering inmates with histories of trauma, privacy concerns, etc.).

The designation to a facility of the inmate's identified gender would be appropriate only in rare cases after consideration of all of the above factors and where there has been significant progress

towards transition as demonstrated by medical and mental health history, as well as positive institution adjustments.

It will be noted in SENTRY designation notes that the TEC reviewed the inmate for appropriate institution designation.

8. **DOCUMENTATION AND SENTRY ASSIGNMENTS**

a. **Medical and Mental Health Information**. Medical and mental health information for transgender inmates will be maintained in the current electronic recordkeeping system in accordance with the Program Statement **Health Information Management**. Medical and mental health information is considered confidential, and may only be released in accordance with appropriate laws, rules, and regulations.

b. **Initial Screening**. For initial designations, designations staff will assign Case Management Activity (CMA) SENTRY assignments if information in the PSR or other documentation indicates a likely transgender identity. The screening codes will be:

SCRN M2F – inmate should be screened for male to female.
SCRN F2M – inmate should be screened for female to male.

Any inmate arriving at the designated institution with a screening code is to be referred to the Chief Psychologist or designee for review within 14 days. If the code was assigned in error, the screening code will be removed by the psychologist. If the inmate identifies as transgender, the psychologist will replace the screening code with an identifying code, as indicated below. Holdover facilities will be exempt from this initial screening requirement, as limited available records and brevity of stay do not allow for a comprehensive screening.

Any inmate who arrives without a screening code but identifies as transgender during intake, or at any time during the incarceration period, is referred to the Chief Psychologist or designee and interviewed within 14 days of the inmate notification. Inmates in pretrial status at Bureau facilities may also receive a SENTRY code.

c. **Notification to Staff and Tracking**. After consultation with Psychology Services, and if the inmate affirms his/her transgender identity, the screening code will be updated to a permanent assignment by a psychologist:

TRN M2F – inmate is male to female transgender (transgender female).
TRN F2M – inmate is a female to male transgender (transgender male).

The inmate must request to Psychology Services staff that the CMA assignment be entered, and the inmate consents that all staff will therefore be notified that the individual is transgender. The inmate's request will be documented on BP-A1110, Case Management Activity (CMA) SENTRY Assignment Consent Form for Transgender Inmates (included as Attachment A to this policy). Psychology Services will maintain the form in the electronic mental health record and forward a copy of the form to the Unit Team. The Unit Team will maintain the form in the FOI Exempt section of the Central File.

Staff should consult the CMA assignment when interacting with the inmate; e.g., use of pronouns, searches, commissary items, etc., as indicated below.

If there are questions about the need to continue a CMA assignment, the Warden should contact the Women and Special Populations Branch. Should the CMA assignment change, staff members will not be disciplined for the continued provision of accommodations or use of pronouns.

9. HORMONE AND NECESSARY MEDICAL TREATMENT

Hormone or other necessary medical treatment may be provided after an individualized assessment of the requested inmate by institution medical staff. Medical staff should request consultation from Psychology Services regarding the mental health benefits of hormone or other necessary medical treatment. If appropriate for the inmate, hormone treatment will be provided in accordance with the Program Statement **Patient Care** and relevant clinical guidance. Questions concerning hormone treatment may be referred to the TCCT.

In the event this treatment changes the inmate's appearance to the extent a new identification card is needed, the inmate will not be charged for the identification card.

10. INSTITUTION PSYCHOLOGY SERVICES

Bureau psychologists are available to provide assessment and treatment services for transgender inmates, if appropriate. Guidance on assessment procedures will be provided by the Psychology Services Branch.

If an inmate identifies as transgender, the psychologist will provide the inmate with information regarding the range of treatment options available in the Bureau and their implications. In addition, based upon the psychologist's preliminary assessment and the inmate's expressed interest, a referral to the Clinical Director and/or Chief Psychiatrist may be generated. While the initial interview must be scheduled within 14 days, an assessment may take longer in some instances.

In addition to a referral to medical services, a transgender inmate may be offered individual psychotherapy. Individual psychotherapy goals might include: (1) helping the inmate to live more comfortably within a gender identity and deal effectively with non-gender issues; (2) emphasizing the need to set realistic life goals related to daily living, work, and relationships, including family of origin; (3) seeking to define and address issues that may have undermined a stable lifestyle, such as substance abuse and/or criminality; and (4) addressing any co-occurring mental health issues. Mood disorders, anxiety disorders, substance use disorders, and personality disorders, etc., may also be present; any effective treatment plan will fully address these symptoms.

If an institution has multiple transgender inmates, a support group facilitated by a mental health provider may also be a component of the treatment plan. Common concerns of transgender inmates, which may be addressed effectively in a group setting, include self-esteem issues and relationship issues.

Psychologists who provide mental health treatment for transgender inmates address all mental health needs, including suicide risk, if present.

Psychologists working with transgender inmates are encouraged to consult the Reentry Services Division in Central Office for additional resources.

11. PRONOUNS AND NAMES

Staff interacting with inmates who have a CMA assignment of transgender can use the authorized gender-neutral communication with inmates (e.g., by the legal last name or "Inmate" last name). Transgender inmates often prefer to be called by pronouns of their identified gender identity. Staff may choose to use these gender-specific pronouns or salutations per the inmate's request, and will not be disciplined for doing so.

An official committed name change while in BOP custody must be done consistent with the Program Statement **Correctional Systems Manual**, Chapter 4. The name entered on the inmate's Judgement and Commitment Order will remain the official committed name for all Bureau records (incident reports, progress reviews, sentence calculations, etc.). However, any additional names or aliases can be entered into SENTRY as appropriate.

12. **PAT SEARCHES**

Pat searches of transgender inmates will be conducted in accordance with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**. The policy language, included here as a reference, states:

"Transgender Inmates – For purposes of pat searching, inmates will be pat-searched in accordance with the gender of the institution, or housing assignment, in which they are assigned. Transgender inmates may request an exception. The exception must be pre-authorized by the Warden, after consultation with staff from Health Services, Psychology Services, Unit Management, and Correctional Services. Exceptions must be specifically described (e.g., "pat search only by female staff"), clearly communicated to relevant staff through a memorandum, and reflected in SENTRY (or other Bureau database; e.g., posted picture file). Inmates should be provided a personal identifier (e.g., notation on commissary card, etc.) that indicates their individual exception, to be carried at all times and presented to staff prior to pat searches."

It is recommended the inmate request the exception by submitting an Inmate Request to Staff (BP-A0148) to the Warden. The Warden will consult with the departments listed above, and the memo approving or denying the request will be generated by the Warden's Office.

Inmates who are granted this exception under policy may have it reversed by the Warden if found to have violated institution rules concerning contraband.

In exigent circumstances, any staff member may conduct a pat search of any inmate consistent with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**.

13. **VISUAL SEARCHES**

For purposes of a visual search, inmates will be searched in accordance with the gender of the institution, or housing assignment, to which they are assigned. The visual search shall be made in a manner designed to ensure as much privacy to the inmate as practicable. Staff should consider the physical layout of the institution, and the characteristics of an inmate with a transgender CMA assignment, to adjust conditions of the visual search as needed for the inmate's privacy.

Transgender inmates may also request an exception to be visually searched by a staff member of the inmate's identified gender. The exception must be pre-authorized by the Warden, after consultation with staff from Health Services, Psychology Services, Unit Management, and Correctional Services. Exceptions must be specifically described (e.g., "visual search only by female staff"), clearly communicated to relevant staff through a memorandum, and reflected in SENTRY (or other Bureau database; e.g., posted picture file). Inmates should be provided a

personal identifier (e.g., notation on commissary card, etc.) that indicates their individual exception, to be carried at all times and presented to staff prior to visual searches.

It is recommended the inmate request the exception by submitting an Inmate Request to Staff (BP-A0148) to the Warden. The Warden will consult with the departments listed above, and the memo approving or denying the request will be generated by the Warden's Office.

Inmates who are granted this exception under policy may have it reversed by the Warden if found to have violated institution rules concerning contraband.

Transgender inmates placed at an institution or in a housing unit that does not correspond with their identified gender, and who are granted an exemption as indicated above, will be searched by: bargaining unit staff of the inmate's identified gender who consent to participate in the search; management staff of the inmate's identified gender who consent to participate in the search; or available Health Services clinical staff.

Transgender inmates placed at an institution or in a housing unit of their identified gender will be searched by bargaining unit staff of the inmate's identified gender who consent to participate in the search; management staff of the inmate's identified gender; or available medical staff.

Institutions should consider using available body scanning technology in lieu of visual searches of transgender inmates.

In exigent circumstances, any staff member may conduct a visual search of any inmate consistent with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**.

14. CLOTHING AND COMMISSARY ITEMS

Consistent with safety and security concerns, inmates with the CMA assignment of transgender will have the opportunity to have undergarments of their identified gender even if they are not housed with inmates of the identified gender. Institutional laundry will have available institutional undergarments that fulfill the needs of transgender inmates. Undergarments will not have metal components.

Standardized lists of Commissary items for transgender inmates are available in accordance with the Program Statement **Trust Fund/Deposit Manual**.

Additional items based on an individualized assessment of the transgender inmate may be approved by the Warden. Additional items may be provided by the institution or purchased by the inmate, as appropriate.

Inmates who purchase and/or are provided items under this section will be subject to disciplinary sanctions, including the removal of these items, if they are found to have violated institution rules relating to the possession of these items.

15. REENTRY NEEDS

In accordance with the Program Statement **Release Preparation Program**, institution staff should assist transgender inmates in addressing these issues prior to release or placement in a Residential Reentry Center/Home Confinement.

During initial classifications and Program Reviews, Unit Management will formulate a pre-release plan that will assist transgender inmates in obtaining appropriate identification, finding housing and employment, and providing community resources to reintegrate into the community.

The Reentry Affairs Coordinator may assist staff with identifying these resources. Institution and/or Regional Social Workers should be contacted concerning the continuity of medical care.

The Women and Special Populations Branch and/or Social Workers can be contacted to provide guidance and resources for reentry needs of transgender inmates.

16. ADMINISTRATIVE REMEDIES

Inmates may use the procedures of the Program Statement **Administrative Remedy Program** concerning any issues relating to this policy.

REFERENCES

Program Statements

P1330.18	Administrative Remedy Program (1/6/14)
P4500.11	Trust Fund/Deposit Fund Manual (4/9/15)
P5100.08	Security Designation and Custody Classification Manual (9/12/06)
P5290.15	Intake Screening (3/30/09)
P5310.12	Psychology Services Manual (03/07/95)
P5310.16	Treatment and Care of Inmates with Mental Illness (5/1/14)
P5322.13	Inmate Classification and Program Review (5/16/14)
P5324.08	Suicide Prevention (4/5/07)
P5324.12	Sexually Abusive Behavior Prevention and Intervention Program (6/4/15)
P5325.07	Release Preparation Program (12/31/07)
P5521.06	Searches of Housing Units, Inmates, and Inmate Work Areas (6/4/15)
P5800.15	Correctional Systems Manual (9/23/16)

P6031.04 Patient Care (6/3/14)
P6090.04 Health Information Management (3/2/15)

Federal Regulations
28 CFR part 115

Additional Resources For Clinicians
Diagnostic and Statistical Manual of Mental Disorders (DSM), most current version.
World Professional Association for Transgender Health (WPATH) standards.

BOP Forms
BP-A0148 Inmate Request to Staff
BP-A1110 Case Management Activity (CMA) SENTRY Assignment Consent Form for Transgender Inmates

*ACA Standards (see Program Statement, **Directives Management Manual**, sections 2.5 and 10.3)*

- American Correctional Association Standards for Adult Correctional Institutions, 4th Edition: 4-4056M, 4-4084M, 4-4084.1M, 4-4133M, 4-4180M, 4-4194M, 4-4278M, 4-4281.1M, 4-4281.2M, 4-4281.3M, 4-4281.4M, 4-4281.5M, 4-4281.6M, 4-4281.7M, 4-4281.8M, 4-4362M, 4-4371M, 4-4406M.
- American Correctional Association Performance Based Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-2A-29, 4-ALDF-2A-32, 4-ALDF-2A-34, 4-ALDF-6B-03, 4-ALDF-2C-03, 4-ALDF-4C-22M, 4-ALDF-4C-30M, 4-ALDF-4D-22, 4-ALDF-4D-22-1, 4-ALDF-4D-22-2, 4-ALDF-4D-22-3, 4-ALDF-4D-22-4, 4-ALDF-4D-22-5, 4-ALDF-4D-22-6M, 4-ALDF-4D-22-7, 4-ALDF-4D-22-8, 4-ALDF-7B-08, 4-ALDF-7B-10, 4-ALDF-7B-10-1.
- American Correctional Association Standards for Administration of Correctional Agencies, 2nd Edition: None.
- American Correctional Association Standards for Correctional Training Academies: None.

Records Retention
Requirements and retention guidance for records and information applicable to this program are available in the Records and Information Disposition Schedule (RIDS) on Sallyport.

Attachment A. Case Management Activity (CMA) SENTRY Assignment Consent Form for Transgender Inmates (BP-A1110)

I agree that Bureau of Prisons staff may enter a CMA assignment on SENTRY concerning my gender identity.

I understand that this CMA assignment will identify me as transgender to all staff members.

I understand that the purpose of the CMA assignment is to assist staff members in providing programs and taking measures as described in the Program Statement **Transgender Offender Manual**.

I understand that specific medical and mental health information will not be disclosed to all staff using the CMA assignment; specific medical and mental health information is maintained separately.

Inmate Name:

Register Number:

Signature:

Date:

DoD INSTRUCTION 1300.28

IN-SERVICE TRANSITION FOR TRANSGENDER SERVICE MEMBERS

Originating Component:	Office of the Under Secretary of Defense for Personnel and Readiness
Effective:	October 1, 2016
Releasability:	Cleared for public release. Available on the DoD Issuances Website at http://www.dtic.mil/whs/directives.
Cancels:	Secretary of Defense Memorandum, "Transgender Service Members," July 28, 2015
Approved by:	Ashton Carter, Secretary of Defense

Purpose: This issuance:

- Establishes a construct by which transgender Service members may transition gender while serving.
- Enumerates prerequisites and prescribes procedures for changing a Service member's gender marker in the Defense Enrollment Eligibility Reporting System (DEERS).
- Specifies medical treatment provisions for Active Component (AC) and Reserve Component (RC) transgender Service members.
- Implements the policies and procedures in Directive-type Memorandum 16-005.

EXHIBIT I

TABLE OF CONTENTS

SECTION 1: GENERAL ISSUANCE INFORMATION

1.1. APPLICABILITY. This issuance applies to OSD, the Military Departments (including the Coast Guard at all times, including when it is a Service in the Department of Homeland Security, by agreement with that Department, and in all regards, except as to the requirement to submit issuances implementing this issuance to the Office of the Under Secretary of Defense for Personnel and Readiness 30 days in advance of publication in accordance with Paragraphs 2.1c and 2.2e), the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD.

1.2. POLICY.

a. DoD and the Military Departments will institute policies to provide Service members a process by which, while serving, they may transition gender. These policies are premised on the conclusion that open service by transgender persons who are subject to the same standards and procedures as other members with regard to their medical fitness for duty, physical fitness, uniform and grooming standards, deployability, and retention, is consistent with military service and readiness.

b. The Military Departments and Services recognize a Service member's gender by the member's gender marker in the DEERS. Coincident with that gender marker, the Services apply, and the member is responsible to meet, all standards for uniforms and grooming; body composition assessment (BCA); physical readiness testing (PRT); Military Personnel Drug Abuse Testing Program (MPDATP) participation; and other military standards applied with consideration of the member's gender. As to facilities subject to regulation by the military, the Service member will use those berthing, bathroom, and shower facilities associated with the member's gender marker in DEERS.

c. Service members with a diagnosis from a military medical provider indicating that gender transition is medically necessary, will be provided medical care and treatment for the diagnosed medical condition. Recommendations of a military medical provider will address the severity of the Service member's medical condition and the urgency of any proposed medical treatment. Medical advice to commanders will be provided in a manner consistent with processes used for other medical conditions that may limit the Service member's performance of official duties.

d. Any medical care and treatment provided to an individual Service member in the process of gender transition will be provided in the same manner as other medical care and treatment. Nothing in this issuance will be construed to authorize a commander to deny medically necessary treatment to a Service member.

e. Any determination that a transgender Service member is non-deployable at any time will be consistent with established Military Department and Service standards, as applied to other Service members whose deployability is similarly affected in comparable circumstances unrelated to gender transition.

f. Commanders will assess expected impacts on mission and readiness after consideration of the advice of military medical providers and will address such impacts in accordance with this issuance. In applying the tools described in this issuance, a commander will not accommodate biases against transgender individuals. If a Service member is unable to meet standards or requires an exception to policy (ETP) during a period of gender transition, all applicable tools, including the tools described in this issuance, will be available to commanders to minimize impacts to the mission and unit readiness.

g. When the military medical provider determines that a Service member's gender transition is complete, and at a time approved by the commander in consultation with the transgender Service member, the member's gender marker will be changed in DEERS and the Service member will be recognized in the preferred gender.

SECTION 2: RESPONSIBILITIES

2.1. UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS (USD(P&R)). The USD(P&R):

a. Updates existing DoD issuances, or promulgate new issuances, as appropriate, in accordance with the provisions of this issuance.

b. Expeditiously develops and promulgates education and training materials to provide relevant, useful information for transgender Service members, commanders, military medical providers, and the force.

c. Ensures that the text of proposed revisions to existing Military Department and Service regulations, policies, and guidance, and of any proposed new Military Department and Service issuance, is consistent with this issuance.

d. Issues guidance to the Military Departments, establishing the prerequisites and procedures for changing a Service member's gender marker in DEERS.

2.2. SECRETARIES OF THE MILITARY DEPARTMENTS AND COMMANDANT, UNITED STATES COAST GUARD (USCG). The Secretaries of the Military Departments and the Commandant, USCG:

a. Adhere to all provisions of this issuance.

b. Administer their respective programs, and update existing Military Department regulations, policies, and guidance, or promulgate new issuances, as appropriate, in accordance with the provisions of this issuance.

c. Establish a Service Central Coordination Cell (SCCC) to provide multi-disciplinary (e.g., medical, legal, military personnel management) expert advice and assistance to commanders with regard to service by transgender Service members and gender transition in the military and to assist commanders in the execution of DoD, Military Department, and Service policies and procedures.

d. Educate their AC and RC forces to ensure appropriate understanding of the policies and procedures pertaining to gender transition in the military.

e. Submit to the USD(P&R) the text of any proposed revision to existing Military Department and Service regulations, policies, and guidance, and of any proposed new issuance, not later than 30 days in advance of the proposed publication date.

f. Ensure the protection of personally identifiable information (PII) and personal privacy considerations in the implementation of this issuance and Military Department and Service regulations, policies, and guidance.

g. Implement processes for the assessment and oversight of compliance with DoD, Military Department, and Service policies and procedures applicable to service by transgender persons, in accordance with Paragraph 3.8 of this issuance.

SECTION 3: GENDER TRANSITION

3.1. SPECIAL MILITARY CONSIDERATIONS. Gender transition while serving in the military presents unique challenges associated with addressing the needs of the Service member in a manner consistent with military mission and readiness. Where possible, gender transition should be conducted such that a Service member would meet all applicable standards and be available for duty in the birth gender prior to a change in the member's gender marker in DEERS and would meet all applicable standards and be available for duty in the preferred gender after the change in gender marker. Recognizing, however, that every transition is unique, the policies and procedures set forth herein provide flexibility to the Military Departments, Services, and commanders, in addressing transitions that may or may not follow this construct. These policies and procedures are applicable, in whole or in relevant part, to those Service members who intend to begin transition, are beginning transition, who already may have started transition, and who have completed gender transition and are stable in their preferred gender.

a. Medical.

(1) In accordance with DoD Instructions (DoDIs) 6025.19 and 1215.13, all Service members have a responsibility to maintain their health and fitness, meet individual medical readiness requirements, and report to their chains of command any medical (including mental health) and health issue that may affect their readiness to deploy or fitness to continue serving in an active status.

(2) Each Service member in the AC or in the Selected Reserve will, as a condition of continued participation in military service, report significant health information to their chain of command. Service members who have or have had a medical condition that may limit their performance of official duties, must consult with a military medical provider concerning their diagnosis and proposed treatment, and must notify their commanders.

(3) As in the case of other health issues, when a Service member receives a diagnosis from a military medical provider indicating that gender transition is medically necessary, the member's notification to the commander must identify all medically necessary care and treatment that is part of the Service member's medical treatment plan and a projected schedule for such treatment, including an estimated date for a change in the member's gender marker in DEERS.

b. Gender Transition in the Military. Gender transition begins when a Service member receives a diagnosis from a military medical provider indicating that gender transition is medically necessary, and concludes when the Service member's gender marker in DEERS is changed and the member is recognized in the preferred gender. At that point, the Service member will be responsible for meeting all applicable military standards in the preferred gender, and as to facilities subject to regulation by the military, will use those berthing, bathroom, and shower facilities associated with the preferred gender.

c. Continuity of Medical Care. A military medical provider may determine certain medical care and treatment to be medically necessary, even after a Service member's gender marker is

changed in DEERS (e.g., cross-sex hormone therapy). A gender marker change does not preclude such care and treatment.

d. Living in Preferred Gender. Real Life Experience (RLE) is the phase in the gender transition process during which the individual commences living socially in the gender role consistent with their preferred gender. Although in civilian life this phase is generally categorized by living and working full-time in the preferred gender, consistent application of military standards will normally require that RLE occur in an off-duty status and away from the Service member's place of duty, prior to the change of a gender marker in DEERS.

e. DEERS. The Military Departments and Services recognize a Service member's gender by the member's gender marker in DEERS. Coincident with that gender marker, the Services apply, and the member is responsible to meet, all standards for uniforms and grooming; BCA; PRT; MPDATP participation; and other military standards applied with consideration of the member's gender. As to facilities subject to regulation by the military, the Service member will use those berthing, bathroom, and shower facilities associated with the member's gender marker in DEERS.

f. Military Readiness. Unique to military service, the commander is responsible and accountable for the overall readiness of his or her command. The commander is also responsible for the collective morale and welfare and good order and discipline of the unit, the command climate, and for ensuring that all members of the command are treated with dignity and respect. When a commander receives any request from a Service member that entails a period of non-availability for duty (e.g., necessary medical treatment, ordinary leave, emergency leave, temporary duty, other approved absence), the commander must consider the individual need associated with the request and the needs of the command, in making a decision on that request.

3.2. ROLES AND RESPONSIBILITIES. The individual Service member, the military medical provider, the commander, and each of the Military Departments have crucial roles and responsibilities in the process of gender transition in the military.

a. Service Member's Role.

(1) Secure a medical diagnosis from a military medical provider.

(2) Notify the commander of a diagnosis indicating that gender transition is medically necessary, and identify all medically necessary treatment that is part of the member's medical treatment plan and a projected schedule for such treatment, including an estimated date for a change in the member's gender marker in DEERS, as set forth in Paragraph 3.1.a.

(3) Notify the commander of any change to the medical treatment plan, the projected schedule for **such** treatment, or the estimated date on which the member's gender marker would be changed in DEERS.

b. Military Medical Provider's Role.

(1) Establish the member's medical diagnosis, recommend medically necessary care and treatment, and, in consultation with the Service member, develop a medical treatment plan associated with the Service member's gender transition, as set forth in Paragraph 3.1.a, for submission to the commander.

(2) In accordance with established military medical practices, advise the commander on the medical diagnosis applicable to the Service member, including the provider's assessment of the medically necessary care and treatment, the urgency of the proposed care and treatment, the likely impact of the care and treatment on the individual's readiness and deployability, and the scope of the human and functional support network needed to support the individual.

(3) In consultation with the Service member, formally advise the commander when the Service member's gender transition is complete, and recommend to the commander a time at which the member's gender marker may be changed in DEERS.

(4) Provide the Service member with medically necessary care and treatment after the member's gender marker has been changed in DEERS.

c. Commander's Role.

(1) Review a Service member's request to transition gender. Ensure, as appropriate, a transition process that:

(a) Complies with DoD, Military Department, and Service regulations, policies, and guidance.

(b) Considers the individual facts and circumstances presented by the Service member.

(c) Ensures military readiness by minimizing impacts to the mission (including deployment, operational, training, and exercise schedules, and critical skills availability), as well as to the morale and welfare, and good order and discipline of the unit.

(d) Is consistent with the medical treatment plan.

(e) Incorporates consideration of other factors, as appropriate.

(2) Coordinate with the military medical provider regarding any medical care or treatment provided to the Service member, and any medical issues that arise in the course of a Service member's gender transition.

(3) Consult with the SCCC with regard to service by transgender Service members and gender transition in the military, the execution of DoD, Military Department, and Service policies and procedures, and assessment of the means and timing of any proposed medical care or treatment.

d. Role of the Military Department and the USCG.

(1) Establish policies and procedures in accordance with this issuance, outlining the actions a commander may take to minimize impacts to the mission and ensure continued unit readiness in the event that a transitioning individual is unable to meet standards or requires an ETP during a period of gender transition. Such policies and procedures may address the means and timing of transition, procedures for responding to a request for an ETP prior to the change of a Service member's gender marker in DEERS, appropriate duty statuses, and tools for addressing any inability to serve throughout the gender transition process. Any such actions available to the commander will consider and balance the needs of the individual and the needs of the command in a manner comparable to the actions available to the commander in addressing comparable Service member circumstances unrelated to gender transition. Such actions may include:

(a) Adjustments to the date on which the Service member's gender transition, or any component of the transition process, will commence.

(b) Advising the Service member of the availability of options for extended leave status or participation in other voluntary absence programs during the transition process.

(c) Arrangements for the transfer of the Service member to another organization, command, location, or duty status (e.g., Individual Ready Reserve), as appropriate, during the transition process.

(d) ETPs associated with changes in the member's physical appearance and body composition during gender transition, such as accommodations in the application of standards for uniforms and grooming, BCA, PRT, and MPDATP participation.

(e) Establishment of, or adjustment to, local policies on the use of berthing, bathroom, and shower facilities subject to regulation by the military, during the transition process.

(f) Referral for a determination of fitness in the disability evaluation system in accordance with DoDI 1332.18.

(g) Other actions, including the initiation of administrative or other proceedings, comparable to actions that could be initiated with regard to others whose ability to serve is similarly affected for reasons unrelated to gender transition.

(2) Establish policies and procedures, consistent with this issuance, whereby a Service member's gender marker will be changed in DEERS based on a determination by the military medical provider that the Service member's gender transition is complete; receipt of written approval from the commander, issued in consultation with the Service member; and production by the Service member of documentation indicating gender change. Such documentation is limited to:

(a) A certified true copy of a State birth certificate reflecting the Service member's preferred gender;

(b) A certified true copy of a court order reflecting the Service member's preferred gender; or

(c) A United States passport reflecting the member's preferred gender.

(3) When the Service member's gender marker in DEERS is changed:

(a) Apply uniform standards, grooming standards, BCA standards, PRT standards, MPDATP standards, and other standards applied with consideration of the member's gender, applicable to the Service member's gender as reflected in DEERS.

(b) As to facilities that are subject to regulation by the military, direct the use of berthing, bathroom, and shower facilities according to the Service member's gender marker as reflected in DEERS.

3.3. GENDER TRANSITION APPROVAL PROCESS.

a. A Service member on active duty, who receives a diagnosis from a military medical provider for which gender transition is medically necessary may, in consultation with the military medical provider and at the appropriate time, request that the commander approve:

(1) The timing of medical treatment associated with gender transition;

(2) An ETP associated with gender transition, consistent with Paragraph 3.2.d, and/or

(3) A change to the Service member's gender marker in DEERS.

b. The commander, informed by the recommendations of the military medical provider, the SCCC, and others, as appropriate, will respond to the request within a framework that ensures readiness by minimizing impacts to the mission (including deployment, operational, training, exercise schedules, and critical skills availability), as well as to the morale and welfare and good order and discipline of the command.

c. Consistent with applicable law, regulation, and policy, the commander will:

(1) Comply with the provisions of this issuance, and with Military Department and Service regulations, policies, and guidance, and consult with the SCCC.

(2) Promptly respond to any request for medical care, as identified by the military medical provider, and ensure that such care is provided consistent with applicable regulations.

(3) Respond to any request for medical treatment or an ETP associated with gender transition, as soon as practicable, but not later than, 90 days after receiving a request determined to be complete in accordance with the provisions of this issuance and Military Department and Service regulations, policies, and guidance. The response will be in writing; include notice of any actions taken by the commander in accordance with applicable regulations, policies, and guidance and the provisions of this issuance; and will be provided to both the Service member

and their military medical provider. A request that, upon review by the commander, is determined to be incomplete, will be returned to the Service member, with written notice of the deficiencies identified, as soon as practicable, but not later than 30 days after receipt.

(4) At any time prior to the change of the Service member's gender marker in DEERS, the commander may modify a previously approved approach to, or an ETP associated with, gender transition. A determination that modification is necessary and appropriate will be made in accordance with the procedures, and upon review and consideration of the factors set forth in Paragraph 3.2.c of this issuance. Notice of such modification will be provided to the Service member under procedures established by the Secretary of the Military Department concerned, and may include options as set forth in Paragraph 3.2.d.

(5) The commander will approve, in writing, the change of a Service member's gender marker in DEERS, subsequent to receipt of the recommendation of the military medical provider that the member's gender marker be changed and receipt of the requisite documentation from the Service member. Upon submission of the commander's written approval to the appropriate personnel servicing activity, the change in the Service member's gender marker will be entered in the database and transmitted to and updated in DEERS, under the authority, direction, and control of the Defense Manpower Data Center.

d. As authorized by Military Department and Service regulations, policies, and guidance implementing this issuance, a Service member may request review by a senior officer in the chain of command, of a subordinate commander's decision with regard to any request under this issuance and any subsequent modifications to that decision.

3.4. ADDITIONAL RC CONSIDERATIONS.

a. General. Excepting only those special considerations set forth below, RC personnel are subject to all policies and procedures applicable to AC Service members as set forth in this issuance and in Military Department and Service regulations, policies, and guidance implementing this issuance.

b. Gender transition approach. All RC Service members (except Selected Reserve full-time support personnel) identifying as transgender individuals, will submit to, and coordinate with their chain of command, evidence of a medical evaluation that includes a medical treatment plan. Selected Reserve full-time support personnel will follow the gender transition approval process set forth in Paragraph 3.3.

c. Medical treatment plans. A medical treatment plan established by a civilian medical provider will be subject to review and approval by a military medical provider.

d. Selected Reserve Drilling Member Participation. To the greatest extent possible, commanders and Service members will address periods of non-availability for any period of military duty, paid or unpaid, during the member's gender transition with a view to mitigating unsatisfactory participation. In accordance with DoDI 1215.13, such mitigation strategies may include:

(1) Rescheduled training.

(2) Authorized absences.

(3) Alternate training.

e. Delayed Training Program. Delayed Training Program personnel must be advised by recruiters and commanders of limitations resulting from being non-duty qualified. As appropriate, Service members in the Delayed Training Program may be subject to the provisions of Paragraph 3.5 of this issuance.

f. Split Option Training. When authorized by the Military Department concerned, Service members who elect to complete basic and specialty training over two non-consecutive periods may be subject to the provisions of Paragraph 3.5 of this issuance.

3.5. INITIAL ENTRY TRAINING AND CONSIDERATIONS ASSOCIATED WITH THE FIRST TERM OF SERVICE.

a. A blanket prohibition on gender transition during a Service member's first term of service is not permissible. However, the Department recognizes that the All-Volunteer Force readiness model is largely based on those newly accessed into the military being ready and available for multiple training and deployment cycles during their first term of service. This readiness model may be taken into consideration by a commander in evaluating a request for medical care or treatment or an ETP associated with gender transition during a Service member's first term of service. Any other facts and circumstances related to an individual Service member that impact that model will be considered by the commander as set forth in this issuance and implementing Military Department and Service regulations, policies, and guidance.

b. The following policies and procedures apply to Service members during the first term of service and will be applied to Service members with a diagnosis indicating that gender transition is medically necessary in the same manner, and to the same extent, as to Service members with other medical conditions that have a comparable impact on the member's ability to serve:

(1) A Service member is subject to separation in an entry-level status during the period of initial training (defined as 180 days per DoDI 1332.14) based on a medical condition that impairs the Service member's ability to complete such training.

(2) An individual participant is subject to separation from the Reserve Officers' Training Corps in accordance with DoDI 1215.08, or from a Service Academy in accordance with DoDI 1322.22, based on a medical condition that impairs the individual's ability to complete such training or to access into the Armed Forces, under the same terms and conditions applicable to participants in comparable circumstances not related to transgender persons or gender transition. As with all cadets or midshipmen who experience a medical condition while in the Reserve Officers' Training Corps Program or at a Service Academy, each situation is unique and will be evaluated based on its individual circumstances; however, the individual will be required

to meet medical accession standards as a prerequisite to graduation and appointment in the Armed Forces.

(3) A Service member is subject to administrative separation for a fraudulent or erroneous enlistment or induction when warranted and in accordance with DoDI 1332.14, based on any deliberate material misrepresentation, omission, or concealment of a fact, including a medical condition, that if known at the time of enlistment, induction, or entry into a period of military service, might have resulted in rejection.

(4) If a Service member requests non-urgent medical treatment or an ETP associated with gender transition during the first term of service, including during periods of initial entry training in excess of 180 days, the commander may give the factors set forth in Paragraph 3.5.a significant weight in considering and balancing the individual need associated with the request and the needs of the command, in determining when such treatment, or whether such ETP may commence in accordance with Paragraph 3.2.d.

3.6. PROTECTION OF PII AND PROTECTED HEALTH INFORMATION.

a. In accordance with DoDD 5400.11, in cases in which there is a need to collect, use, maintain, or disseminate PII in furtherance of this issuance or Military Department and Service regulations, policies, or guidance, the Military Departments and the USCG will protect against unwarranted invasions of personal privacy and the unauthorized disclosure of such PII. The Military Departments and the USCG will maintain such PII so as to protect individual's rights, consistent with federal law, regulation, and policy.

b. Disclosure of protected health information will be consistent with DoD 6025.18-R.

3.7. PERSONAL PRIVACY CONSIDERATIONS. A commander may employ reasonable accommodations to respect the privacy interests of Service members.

3.8. ASSESSMENT AND OVERSIGHT OF COMPLIANCE.

a. The Secretaries of the Military Departments and the Commandant, USCG, will implement processes for the assessment and oversight of compliance with DoD, Military Department, and Service policies and procedures applicable to service by transgender persons.

b. Beginning in 2018 and no less frequently than triennially thereafter, Secretaries of the Military Departments and the Commandant, USCG, will direct an Inspector General Special Inspection of compliance with this issuance and implementing Military Department or USCG regulations, policies, and guidance. The directing official will review the Report of Inspection for purposes of assessing and overseeing compliance; identifying compliance deficiencies, if any; timely initiating corrective action, as appropriate; and deriving best practices and lessons learned.

GLOSSARY

G.1. ACRONYMS.

AC	Active Component
BCA	body composition assessment
DEERS	Defense Enrollment Eligibility Reporting System
DoDI	DoD instruction
ETP	exception to policy
MPDATP	military personnel drug abuse testing program
PII	personally identifiable information
PRT	physical readiness testing
RLE	real life experience
RC	Reserve Component
SCCC	Service Central Coordination Cell
USCG	United States Coast Guard
USD(P&R)	Under Secretary of Defense for Personnel and Readiness

G.2. DEFINITIONS. Unless otherwise noted, these terms and their definitions are for the purpose of this issuance.

cross-sex hormone therapy. The use of feminizing hormones in an individual assigned male at birth based on traditional biological indicators or the use of masculinizing hormones in an individual assigned female at birth. A common medical treatment associated with gender transition.

gender marker. Data element in DEERS that identifies a Service member's gender. A Service member is expected to adhere to all military standards associated with the member's gender marker in DEERS and use military berthing, bathroom, and shower facilities in accordance with the DEERS gender marker.

gender transition is complete. A Service member has completed the medical care identified or approved by a military medical provider in a documented medical treatment plan as necessary to achieve stability in the preferred gender.

gender transition process. Gender transition in the military begins when a Service member receives a diagnosis from a military medical provider indicating that the member's gender transition is medically necessary, and concludes when the Service member's gender marker in DEERS is changed and the member is recognized in the preferred gender.

human and functional support network. Support network for a Service member that may be informal (e.g., friends, family, co-workers, social media.) or formal (e.g., medical professionals, counselors, clergy).

medically necessary. Those health-care services or supplies necessary to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, and that meet accepted standards of medicine.

non-urgent medical care. The care required to diagnose and treat problems that are not life or limb threatening or that do not require immediate attention.

preferred gender. The gender in which a transgender Service member will be recognized when that member's gender transition is complete and the member's gender marker in DEERS is changed.

RLE. The phase in the gender transition process during which the individual commences living socially in the gender role consistent with their preferred gender. RLE may or may not be preceded by the commencement of cross-sex hormone therapy, depending on the medical treatment associated with the individual Service member's gender transition. The RLE phase is also a necessary precursor to certain medical procedures, including gender transition surgery. RLE generally encompasses dressing in the new gender, as well as using preferred gender berthing, bathroom, and shower facilities.

SCCC. Service-level cell of experts created to provide multi-disciplinary (e.g., medical, legal) advice and assistance to commanders with regard to service by transgender Service members and gender transition in the military.

stable in the preferred gender. Medical care identified or approved by a military medical provider in a documented medical treatment plan is complete, no functional limitations or complications persist, and the individual is not experiencing clinically significant distress or impairment in social, occupational, or other important areas of functioning. Continuing medical care, including but not limited to cross-sex hormone therapy, may be required to maintain a state of stability.

transgender Service member. A Service member who has received a medical diagnosis indicating that gender transition is medically necessary, including any Service member who intends to begin transition, is undergoing transition, or has completed transition and is stable in the preferred gender.

transition. Period of time when individuals change from the gender role associated with their sex assigned at birth to a different gender role. For many people, this involves learning how to live socially in another gender role; for others this means finding a gender role and expression that are most comfortable for them. Transition may or may not include feminization or masculinization of the body through cross-sex hormone therapy or other medical procedures. The nature and duration of transition are variable and individualized.

urgent medical care. The care needed to diagnose and treat serious or acute medical conditions that pose no immediate threat to life and health, but require medical attention within 24 hours.

REFERENCES

Directive-type Memorandum 16-005, "Military Service of Transgender Service Members," July 1, 2016

DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 24, 2003

DoD Directive 5400.11, "DoD Privacy Program," October 29, 2014

DoD Instruction 1215.08, "Senior Reserve Officers' Training Corps (ROTC) Programs," June 26, 2006

DoD Instruction 1215.13, "Ready Reserve Member Participation Policy," May 5, 2015

DoD Instruction 1322.22, "Service Academies," September 24, 2015

DoD Instruction 1332.14, "Enlisted Administrative Separations," January 27, 2014, as amended

DoD Instruction 1332.18, "Disability Evaluation System (DES)," August 5, 2014

DoD Instruction 6025.19, "Individual Medical Readiness (IMR)," June 9. 2014

When Children Say They're Trans

Hormones? Surgery? The choices are fraught—and there are no easy answers.

Maciek Jasik

JESSE SINGAL

JULY/AUGUST 2018 ISSUE | HEALTH

CLAIRE IS A 14-YEAR-OLD GIRL with short auburn hair and a broad smile. She lives outside Philadelphia with her mother and father, both professional scientists. Claire can come across as an introvert, but she quickly opens up, and what seemed like shyness reveals itself to be quiet self-assuredness. Like many kids her age, she is a bit overscheduled. During the course of the evening I spent with Claire and her mother, Heather—these aren't their real names—theater, guitar, and track tryouts all came up. We also discussed the fact that, until recently, she wasn't certain she was a girl.

EXHIBIT J

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Sixth grade had been difficult for her. She'd struggled to make friends and experienced both anxiety and depression. "I didn't have any self-confidence at all," she told me. "I thought there was something wrong with me." Claire, who was 12 at the time, also felt uncomfortable in her body in a way she couldn't quite describe. She acknowledged that part of it had to do with puberty, but she felt it was more than the usual preteen woes. "At first, I started eating less," she said, "but that didn't really help."

Around this time, Claire started watching YouTube videos made by transgender young people. She was particularly fascinated by MilesChronicles, the channel of Miles McKenna, a charismatic 22-year-old. His 1 million subscribers have followed along as he came out as a trans boy, went on testosterone, got a double mastectomy, and transformed into a happy, healthy young man. Claire had discovered the videos by accident, or rather by algorithm: They'd showed up in her "recommended" stream. They gave a name to Claire's discomfort. She began to wonder whether she was transgender, meaning her internal gender identity didn't match the sex she had been assigned at birth. "*Maybe the reason I'm uncomfortable with my body is I'm supposed to be a guy*," she thought at the time.

Claire found in MilesChronicles and similar YouTube videos a clear solution to her unhappiness. "I just wanted to stop feeling bad, so I was like, *I should just transition*," she said. In Claire's case, the first step would be gaining access to drugs that would halt puberty; next, she would start taking testosterone to develop male secondary sex characteristics. "I thought that that was what made you feel better," she told me.

In Claire's mind, the plan was concrete, though neither Heather nor her husband, Mike, knew about any of it. Claire initially kept her feelings from her parents, researching steps she could take toward transitioning that wouldn't require medical

sound deeper and into binders to hide her breasts. But one day in August 2016, Mike asked her why she'd seemed so sad lately. She explained to him that she thought she was a boy.

This began what Heather recalls as a complicated time in her and her husband's relationship with their daughter. They told Claire that they loved and supported her; they thanked her for telling them what she was feeling. But they stopped short of encouraging her to transition. "We let her completely explore this on her own," Heather told me.

To Claire's parents, her anguish seemed to come out of nowhere. Her childhood had been free of gender dysphoria—the clinical term for experiencing a powerful sense of disconnection from your assigned sex. They were concerned that what their daughter had self-diagnosed as dysphoria was simply the travails of puberty.

As Claire passed into her teen years, she continued to struggle with mental-health problems. Her parents found her a therapist, and while that therapist worked on Claire's depression and anxiety—she was waking up several times a night to make sure her alarm clock was set correctly—she didn't feel qualified to help her patient with gender dysphoria. The therapist referred the family to some nearby gender-identity clinics that offered transition services for young people.

Claire's parents were wary of starting that process. Heather, who has a doctorate in pharmacology, had begun researching youth gender dysphoria for herself. She hoped to better understand why Claire was feeling this way and what she and Mike could do to help. Heather concluded that Claire met the clinical criteria for gender dysphoria in the *DSM-5*, the American Psychiatric Association's diagnostic manual. Among other indications, her daughter clearly didn't feel like a girl, clearly wanted a boy's body, and was deeply distressed by these feelings. But Heather questioned whether these criteria, or much of the information she found online, told the whole story. "Psychologists know that adolescence is fraught with uncertainty and identity searching, and this isn't even acknowledged," she told me.

Heather said most of the resources she found for parents of a gender-dysphoric child told her that if her daughter said she was trans, she was trans. If her daughter said she needed hormones, Heather's responsibility was to help her get on hormones. The most important thing she could do was *affirm* her daughter, which Heather and Mike interpreted as meaning they should agree with her declarations that she was transgender. Even if they weren't so certain.

AS HEATHER WAS SEARCHING FOR ANSWERS, Claire's belief that she should transition was growing stronger. For months, she had been insistent that she wanted both testosterone and "top surgery"—a double mastectomy. She repeatedly asked her parents to find her doctors who could get her started on a path to physical transition. Heather and Mike bought time by telling her they were looking but hadn't been able to find anyone yet. "We also took her kayaking, played more board games with her and watched more TV with her, and took other short family trips," Heather recalled. "We also took away her ability to search online but gave her Instagram as a consolation." They told her they realized that she was in pain, but they also felt, based on what they'd learned in their research, that it was possible her feelings about her gender would change over time. They asked her to start keeping a journal, hoping it would help her explore those feelings.

Claire humored her parents, even as her frustration with them mounted. Eventually, though, something shifted. In a journal entry Claire wrote last November, she traced her realization that she wasn't a boy to one key moment. Looking in the mirror at a time when she was trying to present in a very male way—at "my baggy, uncomfortable clothes; my damaged, short hair; and my depressed-looking face"—she found that "it didn't make me feel any better. I was still miserable, and I still hated myself." From there, her distress gradually began to lift. "It was kind of sudden when I thought: *You know, maybe this isn't the right answer—maybe it's something else*," Claire told me. "But it took a while to actually set in that yes, I was definitely a girl."

Claire believes that her feeling that she was a boy stemmed from rigid views of gender roles that she had internalized. "I think I really had it set in stone what a guy

was supposed to be like and what a girl was supposed to be like. I thought that if you didn't follow the stereotypes of a girl, you were a guy, and if you didn't follow the stereotypes of a guy, you were a girl." She hadn't seen herself in the other girls in her middle-school class, who were breaking into cliques and growing more gossipy. As she got a bit older, she found girls who shared her interests, and started to feel at home in her body.

Heather thinks that if she and Mike had heeded the information they found online, Claire would have started a physical transition and regretted it later. These days, Claire is a generally happy teenager whose mental-health issues have improved markedly. She still admires people, like Miles McKenna, who benefited from transitioning. But she's come to realize that's just not who she happens to be.

THE NUMBER OF SELF-IDENTIFYING TRANS PEOPLE in the United States is on the rise. In June 2016, the Williams Institute at the UCLA School of Law estimated that 1.4 million adults in the U.S. identify as transgender, a near-doubling of an estimate from about a decade earlier. As of 2017, according to the institute, about 150,000 teenagers ages 13 to 17 identified as trans. The number of young people seeking clinical services appears to be growing as well. A major clinic in the United Kingdom saw a more than 300 percent increase in new referrals over the past three years. In the U.S., where youth gender clinics are somewhat newer—40 or so are scattered across the country—solid numbers are harder to come by. Anecdotally, though, clinicians are reporting large upticks in new referrals, and waiting lists can stretch to five months or longer.

How can parents get children the support they might need while keeping in mind that adolescence is, by definition, a time of identity exploration?

The current era of gender-identity awareness has undoubtedly made life easier for many young people who feel constricted by the sometimes-oppressive nature of gender expectations. A rich new language has taken root, granting kids who might

have felt alone or excluded the words they need to describe their experiences. And the advent of the internet has allowed teenagers, even ones in parts of the country where acceptance of gender nonconformity continues to come far too slowly, to find others like them.

But when it comes to the question of physical interventions, this era has also brought fraught new challenges to many parents. Where is the line between not "feeling like" a girl because society makes it difficult to *be* a girl and needing hormones to alleviate dysphoria that otherwise won't go away? How can parents tell? How can they help their children gain access to the support and medical help they might need, while also keeping in mind that adolescence is, by definition, a time of fevered identity exploration?

Maciek Jasik

There is no shortage of information available for parents trying to navigate this difficult terrain. If you read the bible of medical and psychiatric care for transgender people—the *Standards of Care* issued by the World Professional Association for Transgender Health (WPATH)—you'll find an 11-page section called

"Assessment and Treatment of Children and Adolescents With Gender Dysphoria." It states that while some teenagers should go on hormones, that decision should be made with deliberation: "Before any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken." The American Psychological Association's guidelines sound a similar note, explaining the benefits of hormones but also noting that "adolescents can become intensely focused on their immediate desires." It goes on: "This intense focus on immediate needs may create challenges in assuring that adolescents are cognitively and emotionally able to make life-altering decisions."

The leading professional organizations offer this guidance. But some clinicians are moving toward a faster process. And other resources, including those produced by major LGBTQ organizations, place the emphasis on acceptance rather than inquiry. The Human Rights Campaign's "Transgender Children & Youth: Understanding the Basics" web page, for example, encourages parents to seek the guidance of a gender specialist. It also asserts that "being transgender is not a phase, and trying to dismiss it as such can be harmful during a time when your child most needs support and validation." Similarly, parents who consult the pages tagged "transgender youth" on GLAAD's site will find many articles about supporting young people who come out as trans but little about the complicated diagnostic and developmental questions faced by the parents of a gender-exploring child.

HRC, GLAAD, and like-minded advocacy groups emphasize the acceptance of trans kids for understandable reasons: For far too long, parents, as well as clinicians, denied the possibility that trans kids and teens even existed, let alone that they should be allowed to transition. Many such organizations are primarily concerned with raising awareness and correcting still-common misconceptions.

A similar motive seems to animate much of the media coverage of transgender young people. Two genres of coverage have emerged. Dating back at least to the 1993 murder of the Nebraska 21-year-old Brandon Teena, which inspired a documentary as well as the film *Boys Don't Cry*, a steady stream of horror stories

has centered on bullying, physical assault, and suicide—real risks that transgender and gender-nonconforming (TGNC) young people still face.

More recently, a wave of success stories has appeared. In many of these accounts, kids are lost, confused, and frustrated right up until the moment they are allowed to grow their hair out and adopt a new name, at which point they finally become their true self. Take, for example, a Parents.com article in which a mother, writing pseudonymously, explains that she struggled with her child's gender-identity issues for years, until finally turning to a therapist, who, after a 20-minute evaluation, pronounced the child trans. Suddenly, everything clicked into place. The mother writes: "I looked at the child sitting between my husband and me, the child who was smiling, who appeared so happy, who looked as if someone finally saw him or her the way she or he saw him or herself." In a *National Geographic* special issue on gender, the writer Robin Marantz Henig recounts the story of a mother who let her 4-year-old, assigned male at birth, choose a girl's name, start using female pronouns, and attend preschool as a girl. "Almost instantly the gloom lifted," Henig writes.

For many young people in early studies, transitioning appears to have greatly alleviated their dysphoria. But it's not the answer for everyone.

Accounts of successful transitions can help families envision a happy outcome for a suffering child. And some young people clearly experience something like what these caterpillar-to-butterfly narratives depict. They have persistent, intense gender dysphoria from a very young age, and transitioning alleviates it. "Some kids don't waver" in their gender identity, Nate Sharon, a psychiatrist who oversaw a gender clinic in New Mexico for two and a half years, and who is himself trans, told me when we spoke in 2016. "I'm seeing an 11-year-old who at age 2 went up to his mom and said, 'When am I going to start growing my penis? Where's my penis?' At 2."

But these stories tend to elide the complexities of being a TGNC young person, or the parent of one. Some families will find a series of forking paths, and won't always know which direction is best. Like Claire's parents, they may be convinced that their child is in pain, but also concerned that physical transition is not the solution, at least not for a young person still in the throes of adolescence.

WE ARE STILL IN THE EARLIEST STAGES of understanding how physical transitioning affects dysphoric young people. While the specifics depend on your child's age, and can vary from case to case, the transition process for a persistently dysphoric child typically looks something like the following. First, allow your child to transition socially: to adopt the pronouns and style of dress of their authentic gender, and to change their name if they wish. As your child approaches adolescence, get them puberty-blocking drugs, because developing the secondary sex characteristics of their assigned sex could exacerbate their gender dysphoria. When they reach their teen years, help them gain access to the cross-sex hormones that will allow them to develop secondary sex characteristics in line with their gender identity. (Until recently, hormones were typically not prescribed until age 16; it's now more common for 15- and 14-year-olds, and sometimes even younger kids, to begin hormone therapy.)

In the United States, avoiding puberty became an option only a little more than a decade ago, so researchers have just begun tracking the kids engaged in this process, and we don't yet have comprehensive data about their long-term outcomes. Most of the data we do have involve kids who socially transitioned at an early age, but who hadn't yet physically transitioned. The information comes from a University of Washington researcher named Kristina Olson. Olson is the founder of the TransYouth Project, which is following a cohort of about 300 children for 20 years—the longest such longitudinal study based in the U.S. The kids she is tracking appear to be doing well—they don't seem all that different, in terms of their mental health and general happiness, from a control group of cisgender kids (that is, kids who identify with the sex they were assigned at birth).

At the prestigious Center of Expertise on Gender Dysphoria, at Vrije Universiteit University Medical Center, in Amsterdam—often referred to simply as "the Dutch clinic"—an older cohort of kids who went through the puberty-blockers-and-cross-sex-hormones protocol was also found to be doing well: "Gender dysphoria had resolved," according to a study of the group published in 2014 in *Pediatrics*. "Psychological functioning had steadily improved, and well-being was comparable to same-age peers."

These early results, while promising, can tell us only so much. Olson's findings come from a group of trans kids whose parents are relatively wealthy and are active in trans-support communities; they volunteered their children for the study. There are limits to how much we can extrapolate from the Dutch study as well: That group went through a comprehensive diagnostic process prior to transitioning, which included continuous access to mental-health care at a top-tier gender clinic—a process unfortunately not available to every young person who transitions.

Among the issues yet to be addressed by long-term studies are the effects of medications on young people. As Thomas Steensma, a psychologist and researcher at the Dutch clinic and a co-author of that study, explained to me, data about the potential risks of putting young people on puberty blockers are scarce. He would like to see further research into the possible effects of blockers on bone and brain development. (The potential long-term risks of cross-sex hormones aren't well known, but are likely modest, according to Joshua Safer, one of the authors of the Endocrine Society's "Clinical Practice Guideline" for treatment of gender dysphoria.)

Meanwhile, fundamental questions about gender dysphoria remain unanswered. Researchers still don't know what causes it—gender identity is generally viewed as a complicated weave of biological, psychological, and sociocultural factors. In some cases, gender dysphoria may interact with mental-health conditions such as depression and anxiety, but there's little agreement about how or why. Trauma, particularly sexual trauma, can contribute to or exacerbate dysphoria in some patients, but again, no one yet knows exactly why.

To reiterate: For many of the young people in the early studies, transitioning—socially for children, physically for adolescents and young adults—appears to have greatly alleviated their dysphoria. But it's not the answer for everyone. Some kids are dysphoric from a very young age, but in time become comfortable with their body. Some develop dysphoria around the same time they enter puberty, but their suffering is temporary. Others end up identifying as nonbinary—that is, neither male nor female.

Ignoring the diversity of these experiences and focusing only on those who were effectively "born in the wrong body" could cause harm. That is the argument of a small but vocal group of men and women who have transitioned, only to return to their assigned sex. Many of these so-called detransitioners argue that their dysphoria was caused not by a deep-seated mismatch between their gender identity and their body but rather by mental-health problems, trauma, societal misogyny, or some combination of these and other factors. They say they were nudged toward the physical interventions of hormones or surgery by peer pressure or by clinicians who overlooked other potential explanations for their distress.

Some of these interventions are irreversible. People respond differently to cross-sex hormones, but changes in vocal pitch, body hair, and other physical characteristics, such as the development of breast tissue, can become permanent. Kids who go on puberty blockers and then on cross-sex hormones may not be able to have biological children. Surgical interventions can sometimes be reversed with further surgeries, but often with disappointing results.

The concerns of the detransitioners are echoed by a number of clinicians who work in this field, most of whom are psychologists and psychiatrists. They very much support so-called affirming care, which entails accepting and exploring a child's statements about their gender identity in a compassionate manner. But they worry that, in an otherwise laudable effort to get TGNC young people the care they need, some members of their field are ignoring the complexity, and fluidity, of gender-identity development in young people. These colleagues are approving teenagers for hormone therapy, or even top surgery, without fully examining their mental

health or the social and family influences that could be shaping their nascent sense of their gender identity.

That's too narrow a definition of affirming care, in the view of many leading clinicians. "Affirming care does not privilege any one outcome when it comes to gender identity, but instead aims to allow exploration of gender without judgment and with a clear understanding of the risks, benefits, and alternatives to any choice along the way," Aron Janssen, the clinical director of the Gender and Sexuality Service at Hassenfeld Children's Hospital, in New York, told me. "Many people misinterpret affirming care as proceeding to social and medical transition in all cases without delay, but the reality is much more complex."

To make sense of this complex reality—and ensure the best outcome for all gender-exploring kids—parents need accurate, nuanced information about what gender dysphoria is and about the many blank spots in our current knowledge. They don't always get it.

For gender-dysphoric people, physical transition can be life enhancing, even lifesaving. While representative long-term data on the well-being of trans adults have yet to emerge, the evidence that does exist—as well as the sheer heft of personal accounts from trans people and from the clinicians who help them transition—is overwhelming. For many if not most unwaveringly gender-dysphoric people, hormones *work*. Surgery *works*. That's reflected in studies that consistently show low regret rates for the least-reversible physical procedures to address gender dysphoria. One 2012 review of past studies, for example, found that sex-reassignment surgery "is an effective treatment for [gender dysphoria] and the only treatment that has been evaluated empirically with large clinical case series." A study on "bottom surgery," or surgery designed to construct a penis or vagina, found that from 1972 to 2015, "only 0.6 percent of transwomen and 0.3 percent of transmen who underwent [these procedures] were identified as experiencing regret."

Those of us who have never suffered from gender dysphoria can have a hard time appreciating what's at stake. Rebecca Kling, an educator at the National Center for

Transgender Equality, in Washington, D.C., told me that before she transitioned she felt as if she were constantly carrying around a backpack full of rocks. "That is going to make everything in my life harder, and in many cases is going to make things impossible," she said. "Of course being able to remove that heavy burden has added comfort and stability in my sense of myself and my body." Other trans people have offered similar descriptions of gender dysphoria—a weight, a buzzing, an unavoidable source of rumination and worry. Hormones and surgery grant transgender people profound relief.

Historically, they have been denied access to that relief. Christine Jorgensen, the first American to become widely known for transitioning through hormones and surgery, in the 1950s, had to go to Denmark for her care. The trans historian Genny Beemyn notes that Jorgensen's doctor "received more than 1,100 letters from transsexual people, many of whom sought to be his patients," in the months after Jorgensen was treated. As a result of the requests, "the Danish government banned such procedures for non-citizens. In the United States, many physicians simply dismissed the rapidly growing number of individuals seeking gender-affirming surgeries as being mentally ill."

Today, the situation in the U.S. has improved, but the lack of access to transition services continues to be a problem. Whether trans people in this country can access treatments such as hormones and surgery depends on a variety of factors, ranging from where they live to what their health insurance will cover (if they have any) to their ability to navigate piles of paperwork. Erica Anderson, a trans woman and clinical psychologist who works at the Child and Adolescent Gender Center, at UC San Francisco's Benioff Children's Hospital, had no luck when she tried to get hormones from an endocrinologist in Philadelphia just a decade ago. "Even I, with my education and resources, was denied care and access," she told me. "The endocrinologist simply said, 'I don't do that.' I offered to provide her the guidelines from her own Endocrine Society," Anderson said. "She refused and wouldn't even look me in the eye. No referral or offer to help. She sent me away with nothing, feeling like I was an undesirable."

Many trans people have stories like Anderson's. For this reason, among others, trans communities can be skeptical of those who focus on negative transition outcomes. They have long dealt with "professionals who seem uncomfortable giving trans people the go-ahead to transition at all," Zinnia Jones, a trans woman who runs the website GenderAnalysis, told me in an email. They have also faced "unnecessarily protracted timelines for accessing care, a lack of understanding or excess skepticism of our identities from clinicians, and so on."

Groups like WPATH, the primary organization for psychologists, psychiatrists, endocrinologists, surgeons, and others who work with TGNC clients, have attempted to reverse this neglect in recent years. A growing number of adult gender clinics follow "informed consent" protocols, built on the philosophy that trans adults, once informed of the potential benefits and risks of medical procedures, have a right to make their own decisions about their body and shouldn't have their need for services questioned by mental-health and medical professionals.

This shift is seen by many trans people and advocates as an important course correction after decades of gatekeeping—aloof professionals telling trans people they couldn't get hormones or surgery, because they weren't *really* trans, or hadn't been living as a trans person long enough, or were too mentally ill.

FOR GENDER-QUESTIONING CHILDREN AND TEENS, the landscape is different. A minor's legal guardian almost always has to provide consent prior to a medical procedure, whether it's a tonsillectomy or top surgery. WPATH and other organizations that provide guidance for transitioning young people call for thorough assessments of patients before they start taking blockers or hormones.

This caution comes from the concerns inherent in working with young people. Adolescents change significantly and rapidly; they may view themselves and their place in the world differently at 15 than they did at 12. "You've got the onset of puberty right around the age where they develop the concept of abstract thinking," said Nate Sharon, the New Mexico psychiatrist. "So they may start to conceptualize gender concepts in a much richer, broader manner than previously—and then maybe puberty blockers or cross-sex hormones aren't for them." That was true for

Claire: A shift in her understanding of the nature of gender led her to realize that transitioning was not the answer for her.

For younger children, gender identity is an even trickier concept. In one experiment, for example, many 3-to-5-year-olds thought that if a boy put on a dress, he became a girl. Gender clinicians sometimes encounter young children who believe they are, or want to be, another gender because of their dress or play preferences—*I like rough-and-tumble play, so I must be a boy*—but who don't meet the criteria for gender dysphoria.

In the past, therapists and doctors interpreted the fluidity of gender identity among children as license to put gender-bending kids into the "right" box by encouraging—or forcing—them to play with the "right" toys and dress in the "right" clothes. Until about five years ago, according to one clinician's estimate, social transition was often frowned upon. For decades, trans-ness was sometimes tolerated in adults as a last-ditch outcome, but in young people it was more often seen as something to be drummed out rather than explored or accepted. So-called reparative therapy has harmed and humiliated trans and gender-nonconforming children. In her book *Gender Born, Gender Made*, Diane Ehrensaft, the director of mental health at UC San Francisco's Child and Adolescent Gender Center, writes that victims of these practices "become listless or agitated, long for their taken-away favorite toys and clothes, and even literally go into hiding in closets to continue playing with the verboten toys or wearing the forbidden clothes." Such therapy is now viewed as unethical.

Affirming care is far more humane than older philosophies. But it conflicts, at least a little, with what we know about gender-identity fluidity in young people.

These days, mainstream youth-gender clinicians practice affirming care instead. They listen to their young patients, take their statements about their gender seriously, and often help facilitate social and physical transition. Affirming care has

quickly become a professional imperative: Don't question who your clients are—let them tell you who they are, and accept their identity in a nurturing, encouraging manner.

The affirming approach is far more humane than older ones, but it conflicts, at least a little, with what we know about gender-identity fluidity in young people. What does it mean to be affirming while acknowledging that kids and teenagers can have an understanding of gender that changes over a short span? What does it mean to be affirming while acknowledging that feelings of gender dysphoria can be exacerbated by mental-health difficulties, trauma, or a combination of the two?

Clinicians are still wrestling with how to define affirming care, and how to balance affirmation and caution when treating adolescents. "I don't want to be a gatekeeper," Dianne Berg, a co-director of the National Center for Gender Spectrum Health, at the University of Minnesota, told me. "But I also worry that in opening the gates, we're going to have more adolescents that don't engage in the reflective work needed in order to make sound decisions, and there might end up being more people when they are older that are like, *Oh, hmm—now I am not sure about this*."

WHEN MAX ROBINSON WAS 17, getting a double mastectomy made perfect sense to her. In fact, it felt like her only option—like a miraculous, lifesaving procedure. Though she had a woman's body, she was really a man. Surgery would finally offer her a chance to be herself.

I met Max, now 22, in an airy café in the quiet southern-Oregon town where she lives. She was wearing a T-shirt with a flannel button-down over it. On her head, a gray winter cap; at her feet, a shaggy white service dog. By the time we met, we'd spoken on the phone and exchanged a number of emails, and she had told me her story—one that suggests the complexity of gender-identity development.

Max recalled that as early as age 5, she didn't enjoy being treated like a girl. "I questioned my teachers about why I had to make an angel instead of a Santa for a Christmas craft, or why the girls' bathroom pass had ribbons instead of soccer balls,

when I played soccer and knew lots of other girls in our class who loved soccer," she said.

She grew up a happy tomboy—until puberty. "People expect you to grow out of it" at that age, she explained, "and people start getting uncomfortable when you don't." Worse, "the way people treated me started getting increasingly sexualized." She remembered one boy who, when she was 12, kept asking her to pick up his pencil so he could look down her shirt.

"I started dissociating from my body a lot more when I started going through puberty," Max said. Her discomfort grew more internalized—less a frustration with how the world treated women and more a sense that the problem lay in her own body. She came to believe that being a woman was "something I had to control and fix." She had tried various ways of making her discomfort abate—in seventh grade, she vacillated between "dressing like a 12-year-old boy" and wearing revealing, low-cut outfits, attempts to defy and accede to the demands the world was making of her body. But nothing could banish her feeling that womanhood wasn't for her. She had more bad experiences with men, too: When she was 13, she had sex with an older man she was seeing; at the time, it felt consensual, but she has since realized that a 13-year-old can't consent to sex with an 18-year-old. At 14, she witnessed a friend get molested by an adult man at a church slumber party. Around this time, Max was diagnosed with depression and generalized anxiety disorder.

In ninth grade, Max first encountered the concept of being transgender when she watched an episode of *The Tyra Banks Show* in which Buck Angel, a trans porn star, talked about his transition. It opened up a new world of online gender-identity exploration. She gradually decided that she needed to transition.

Max's parents were skeptical at first but eventually came around, signing her up for sessions with a therapist who specialized in gender-identity issues. She recalled that the specialist was very open to putting her on a track toward transition, though he suggested that her discomfort could have other sources as well. Max, however, was certain that transitioning was the answer. She told me that she "refused to talk about anything other than transition."

When Max was 16, her therapist wrote her a referral to see an endocrinologist who could help her begin the process of physical transition by prescribing male hormones. The endocrinologist was skeptical, Max said. "I think what she was seeing was a lesbian teenager," not a trans one. At the time, though, Max interpreted the doctor's reluctance as her "being ignorant, as her trying to hurt me." Armed with the referral from her therapist, Max got the endocrinologist to prescribe the treatment she sought.

Max started taking testosterone. She experienced some side effects—hot flashes, memory issues—but the hormones also provided real relief. Her plan all along had been to get top surgery, too, and the initially promising effects of the hormones helped persuade her to continue on this path. When she was 17, Max, who was still dealing with major mental-health issues, was scheduled for surgery.

Because Max had parental approval, the surgeon she saw agreed to operate on her despite the fact that she was still a minor. (It's become more common for surgeons to perform top surgeries on teenagers as young as 16 if they have parental approval. The medical norms are more conservative when it comes to bottom surgeries; WPATH says they should be performed only on adults who have been living in their gender role for at least one year.) Max went into the surgery optimistic. "I was convinced it would solve a lot of my problems," she said, "and I hadn't accurately named a lot of those problems yet."

Max Robinson went on cross-sex hormones when she was 16 and had a double mastectomy when she was 17. Now 22, she has detransitioned and identifies as a woman. (Chloe Aftel)

Max was initially happy with the results of her physical transformation. Before surgery, she wasn't able to fully pass as male. After surgery, between her newly

masculinized chest and the facial hair she was able to grow thanks to the hormones, she felt like she had left behind the sex she had been assigned at birth. "It felt like an accomplishment to be seen the way I wanted to be seen," she told me.

But that feeling didn't last. After her surgery, Max moved from her native California to Portland and threw herself into the trans scene there. It wasn't a happy home. The clarity of identity she was seeking—and that she'd felt, temporarily, after starting hormones and undergoing surgery—never fully set in. Her discomfort didn't go away.

Today, Max identifies as a woman. She believes that she misinterpreted her sexual orientation, as well as the effects of the misogyny and trauma she had experienced as a young person, as being about gender identity. Because of the hormone therapy, she still has facial hair and is frequently mistaken for male as a result, but she has learned to live with this: "My sense of self isn't entirely dependent on how other people see me."

MAX IS ONE OF WHAT APPEARS TO BE a growing number of people who believe they were failed by the therapists and physicians they went to for help with their gender dysphoria. While their individual stories differ, they tend to touch on similar themes. Most began transitioning during adolescence or early adulthood. Many were on hormones for extended periods of time, causing permanent changes to their voice, appearance, or both. Some, like Max, also had surgery.

Many detransitioners feel that during the process leading up to their transition, well-meaning clinicians left unexplored their overlapping mental-health troubles or past traumas. Though Max's therapist had tried to work on other issues with her, Max now believes she was encouraged to rush into physical transition by clinicians operating within a framework that saw it as the only way someone like her could experience relief. Despite the fact that she was a minor for much of the process, she says, her doctors more or less did as she told them.

“I’m a real-live 22-year-old woman with a scarred chest and a broken voice and a 5 o’clock shadow because I couldn’t face the idea of growing up to be a woman,” said Cari Stella, a detransitioner.

Over the past couple of years, the detransitioner movement has become more visible. Last fall, Max told her story to *The Economist*’s magazine of culture and ideas, *1843*. Detransitioners who previously blogged pseudonymously, largely on Tumblr, have begun writing under their real names, as well as speaking on camera in YouTube videos.

Cari Stella is the author of a blog called Guide on Raging Stars. Stella, now 24, socially transitioned at 15, started hormones at 17, got a double mastectomy at 20, and detransitioned at 22. “I’m a real-live 22-year-old woman with a scarred chest and a broken voice and a 5 o’clock shadow because I couldn’t face the idea of growing up to be a woman,” she said in a video posted in August 2016. “I was not a very emotionally stable teenager,” she told me when we spoke. Transitioning offered a “level of control over how I was being perceived.”

Carey Callahan is a 36-year-old woman living in Ohio who detransitioned after identifying as trans for four years and spending nine months on male hormones. She previously blogged under the pseudonym Maria Catt, but “came out” in a YouTube video in July 2016. She now serves as something of an older sister to a network of female, mostly younger detransitioners, about 70 of whom she has met in person; she told me she has corresponded online with an additional 300. (The detransitioners who have spoken out thus far are mostly people who were assigned female at birth. Traditionally, most new arrivals at youth gender clinics were assigned male; today, many clinics are reporting that new patients are mostly assigned female. There is no consensus explanation for the change.)

I met Carey in Columbus in March. She told me that her decision to detransition grew out of her experience working at a trans clinic in San Francisco in 2014 and 2015. “People had said often to me that when you transition, your gender

dysphoria gets worse before it gets better," she told me. "But I saw and knew so many people who were cutting themselves, starving themselves, never leaving their apartments. That made me doubt the narrative that if you make it all the way to medical transition, then it's probably going to work out well for you."

Carey Callahan serves as something of an older sister to a group of women who, like her, have detransitioned. (Matt Eich)

Carey said she met people who appeared to be grappling with severe trauma and mental illness, but were fixated on their next transition milestone, convinced *that* was the moment when they would get better. "I knew a lot of people committed to that narrative who didn't seem to be doing well," she recalled. Carey's time at the clinic made her realize that testosterone hadn't made *her* feel better in a sustained way either. She detransitioned, moved to Ohio, and is now calling for a more careful approach to treating gender dysphoria than what many detransitioners say they experienced themselves.

In part, that would mean clinicians adhering to guidelines like WPATH's *Standards of Care*, which are nonbinding. "When I look at what the *SOC* describes, and then I

look at my own experience and my friends' experiences of pursuing hormones and surgery, there's hardly any overlap between the directives of the *SOC* and the reality of care patients get," Carey told me. "We didn't discuss all the implications of medical intervention—psychological, social, physical, sexual, occupational, financial, and legal—which the *SOC* directs the mental-health professional to discuss. What the *SOC* describes and the care people get before getting cleared for hormones and surgery are miles apart."

Detransitioners, understandably, elicit suspicion from the trans community. Imagine being a trans person who endured a bruising fight to prove to your psychiatrist and endocrinologist that you are trans, in order to gain access to hormones that greatly improve your quality of life, that relieve suffering. You might view with skepticism—at the very least—a group calling for more gatekeeping. Conservative media outlets, for their part, often seize on detransition narratives to push the idea that being trans is some sort of liberal invention. "How Carey Was Set Free From Transgenderism" was the conservative website LifeSiteNews' disingenuous take on Carey's story.

Video: Reversing a Gender Transition

No one knows how common detransitioning is. A frequently cited statistic—that only 2.2 percent of people who physically transition later regret it—doesn't paint a complete picture. It comes from a study, conducted in Sweden, that examined only those people who had undergone sex-reassignment surgery and legally changed their gender, then applied to change their gender back—a standard that, Carey pointed out, would have excluded her and most of the detransitioners she knows.

It stands to reason that as *any* medical procedure becomes more readily available, a higher number of people will regret having it. Why focus on detransitioners, when no one even knows whether their experiences are all that common? One answer is that clinicians who have logged thousands of hours working with transgender and gender-nonconforming young people are raising the same concerns.

WHEN IT COMES TO HELPING TGNC young people gain access to physical interventions, few American clinicians possess the bona fides of the psychologist Laura Edwards-Leeper. A decade ago, when she was working at Boston Children's Hospital, she visited the Dutch clinic to learn the puberty-blocking protocol pioneered there. She helped bring that protocol back to Boston, where she worked with the first-ever group of American kids to go through that process.

Today, Edwards-Leeper oversees a collaboration between Pacific University and Oregon's Transgender Clinic, within the nonprofit Legacy Health system. At Pacific, she is training clinical-psychology doctoral students to conduct "readiness assessments" for young people seeking physical-transition services.

In February, I visited one of her classes at Pacific, just outside Portland. For an hour, she let me pepper her students with questions about their experiences as clinicians-in-training in what is essentially a brand-new field. When the subject of detransitioners came up, Edwards-Leeper chimed in. "I've been predicting this for, I don't know, the last five or more years," she said. "I anticipate there being more and more and more, because there are so many youth who are now getting services with very limited mental-health assessment and sometimes no mental-health assessment. It's inevitable, I think."

Laura Edwards-Leeper, a clinician at Pacific University and Oregon's Transgender Clinic. She brought the puberty-blocking transition protocol pioneered by the Dutch to the U.S. (Matt Eich)

Edwards-Leeper believes that comprehensive assessments are crucial to achieving good outcomes for TGNC young people, especially those seeking physical interventions, in part because some kids who think they are trans at one point in time will not feel that way later on. This is a controversial subject in some corners of the trans community. A small group of studies has been interpreted as showing that the majority of children who experience gender dysphoria eventually stop experiencing it and come to identify as cisgender adults. (In these studies, children who suffer intense dysphoria over an extended period of time, especially into adolescence, are more likely to identify as trans in the long run.)

This so-called desistance research has been attacked on various methodological grounds. The most-credible critiques center on the claim that some kids who were merely gender *nonconforming*—that is, they preferred stereotypically cross-sex activities or styles of dress—but not *dysphoric* may have been counted as desisters

because the studies relied on outdated diagnostic criteria, artificially pushing the percentage upward. (The terms *detransition* and *desist* are used in different ways by different people. In this article, I am drawing this distinction: Detransitioners are people who undergo social or physical transitions and later reverse them; desisters are people who stop experiencing gender dysphoria without having fully transitioned socially or physically.)

The desistance rate for accurately diagnosed dysphoric kids is probably lower than some of the contested studies suggest; a small number of merely gender-nonconforming kids may indeed have been wrongly swept into even some of the most recent studies, which didn't use the most up-to-date criteria, from the *DSM-5*. And there remains a paucity of big, rigorous studies that might deliver a more reliable figure.

Within a subset of trans advocacy, however, desistance isn't viewed as a phenomenon we've yet to fully understand and quantify but rather as a myth to be dispelled. Those who raise the subject of desistance are often believed to have nefarious motives—the liberal outlet ThinkProgress, for example, referred to desistance research as "the pernicious junk science stalking trans kids," and a subgenre of articles and blog posts attempts to debunk "the desistance myth." But the evidence that desistance occurs is overwhelming. The American Psychological Association, the Substance Abuse and Mental Health Services Administration, the Endocrine Society, and WPATH all recognize that desistance occurs. I didn't speak with a single clinician who believes otherwise. "I've seen it clinically happen," Nate Sharon said. "It's not a myth."

Despite this general agreement, Edwards-Leeper worries that treatment practices are trending toward an interpretation of affirming care that entails nodding along with children and adolescents who say they want physical interventions rather than evaluating whether they are likely to benefit from them.

A decade ago, the opposite was true. "I was constantly having to justify why we should be offering puberty-blocking medication, why we should be supporting these trans youth to get the services they need," Edwards-Leeper recalled. "People

thought this was just crazy, and thought the four-hour evaluations I was doing were, too—how could that possibly be enough to decide whether to go forward with the medical intervention? That was 2007, and now the questions I get are 'Why do you make people go through any kind of evaluation?' And 'Why does mental health need to be involved in this?' And 'We should just listen to what the kids say and listen to what the adolescents say and basically just treat them like adults.'"

The six trainees on Edwards-Leeper's Transgender Youth Assessment Team spoke about the myriad ways mental-health issues and social and cultural influences can complicate a child's conception of gender. "I would say 'affirming' isn't always doing exactly what the kid says they want in the moment," one said. Another added: "Our role as clinicians isn't to confirm or disconfirm someone's gender identity—it's to help them explore it with a little bit more nuance." I asked the students whether they had come across the idea that conducting in-depth assessments is insulting or stigmatizing. They all nodded. "Well, they know what reputation I have," Edwards-Leeper said with a laugh. "I told them about things almost being thrown at me at conferences."

"I think the pendulum has swung so far that now we're maybe not looking as critically at the issues as we should be," says the psychologist Dianne Berg.

Those conference troubles signaled to Edwards-Leeper that her field had shifted in ways she found discomfiting. At one conference a few years ago, she recalled, a co-panelist who was a well-respected clinician in her field said that Edwards-Leeper's comprehensive assessments required kids to "jump through more fiery hoops" and were "retraumatizing." This prompted a standing ovation from the audience, mostly families of TGNC young people. During another panel discussion, at the same conference with the same clinician, but this time geared toward fellow clinicians, the same thing happened: more claims that assessments were traumatizing, more raucous applause.

Edwards-Leeper isn't alone in worrying that the field is straying from its own established best practices. "Under the motivation to be supportive and to be affirming and to be nonstigmatizing, I think the pendulum has swung so far that now we're maybe not looking as critically at the issues as we should be," the National Center for Gender Spectrum Health's Dianne Berg told me. Erica Anderson, the UCSF clinician, expressed similar concerns: "Some of the stories we've heard about detransitioning, I fear, are related to people who hastily embarked on medical interventions and decided that they weren't for them, and didn't thoroughly vet their decision either by themselves or with professional people who could help them."

Even some of the clinicians who have emphasized the need to be deferential to young people acknowledge the complexities at play here. A psychologist with decades of experience working with TGNC young people, Diane Ehrensaft is perhaps the most frequently quoted youth-gender clinician in the country. She is tireless in her advocacy for trans kids. "It's the children who are now leading us," she told *The Washington Post* recently. She sees this as a positive development: "If you listen to the children, you will discover their gender," she wrote in one article. "It is not for us to tell, but for them to say."

But when I spoke with Ehrensaft at her home in Oakland, she described many situations involving physical interventions in which her work was far more complicated than simply affirming a client's self-diagnosis. "This is what I tell kids all the time, particularly teenagers," she said. "Often they're pushing for fast. I say, 'Look, I'm old, you're young. I go slow, you go fast. We're going to have to work that out.'" Sometimes, she said, she suspects that a kid who wants hormones *right now* is simply reciting something he found on the internet. "It just feels wooden, is the only thing I can say," she told me.

At the end of our interview, Ehrensaft showed me a slide from a talk she was preparing about what it means to be an affirming clinician: "REALITY: WE ARE NEITHER RUBBER STAMPERS NOR PUSHERS; WE ARE FACILITATORS." This

isn't so far off from the definition of the clinician's role expressed by Edwards-Leeper's students.

COMPETENT CLINICIANS do occasionally challenge their clients' conception of their gender identity in order to ensure that they are approaching the subject in a sufficiently sophisticated manner. They want to make sure that a given patient has gender dysphoria, as defined in the *DSM-5*, and that their current gender identity is a consistent part of who they are. If a teenager finds that his dysphoria lessens significantly when he presents himself in a more feminine way or once his overlapping mental-health problems have been treated, he may develop a different view on the necessity of hormones or surgery.

This is not to say that talk therapy can cure serious gender dysphoria. Edwards-Leeper worked to introduce the Dutch protocol of blockers and hormones in the United States precisely because she believes that it alleviates dysphoria in cases where there would otherwise be prolonged suffering. But clinicians like her are also careful, given the upheavals of adolescence and the fluid conception of gender identity among young people, not to assume that because a young person has gender dysphoria, they should automatically go on hormones.

Edwards-Leeper is hoping to promote a concept of affirming care that takes into account the developmental nuances that so often come up in her clinical work. In this effort, she is joined by Scott Leibowitz, a psychiatrist who treats children and adolescents. He is the medical director of behavioral health for the THRIVE program at Nationwide Children's Hospital, in Columbus. Leibowitz has a long history of working with and supporting TGNC youth—he served as an expert witness for the Department of Justice in 2016, when President Barack Obama's administration challenged state-level "bathroom bills" that sought to prevent trans people from using the public bathroom associated with their gender identity. Edwards-Leeper and Leibowitz met at Boston Children's, where Leibowitz did his psychiatry fellowship, and the two have been close friends and collaborators ever since.

While it's understandable, for historical reasons, why some people associate comprehensive psychological assessments with denial of access to care, that isn't

how Leibowitz and Edwards-Leeper view their approach. Yes, they want to discern whether a patient actually has gender dysphoria. But comprehensive assessments and ongoing mental-health work are also means of ensuring that transitioning—which can be a physically and emotionally taxing process for adolescents even under the best of circumstances—goes smoothly.

Scott Padberg, one of Edwards-Leeper's patients, is a good example of how her comprehensive-assessment process looks for teenagers with a relatively straightforward history of persistent gender dysphoria and an absence of other factors that might complicate their diagnosis and transition path. I met Scott and his grandmother and legal guardian, Nancy, at a wrap place in Welches, Oregon, not far from where they live. It was a mild February day, so we sat in one of the pine booths outside the restaurant. Mount Hood's massive snowcapped peak loomed nearby.

Scott Padberg, a 16-year-old patient of Laura Edwards-Leeper who went on cross-sex hormones and recently had a double mastectomy (Matt Eich)

Scott, a 16-year-old who radiates calm, explained that despite having been assigned female at birth, he simply never felt like a girl. "I guess I kinda felt different since I felt conscious of the fact that I was alive," he said. For part of his childhood, that was fine with everyone around him. He was granted all the freedom he needed to express himself in a gender-nonconforming manner, from getting short haircuts to playing with stereotypically male toys like dinosaurs and Transformers. But the freedom didn't last. When he was 7, his mom married a "super Christian guy" who tried to impose femininity on him. "It's really degrading," Scott said, to be forced to wear a dress when you're a trans boy. (Scott's mom divorced her devout husband two years later, and Nancy eventually took custody of Scott.)

Puberty brought bigger problems. Scott started developing breasts and got his period. "Everything just sucked, basically," he said. "I was pretty miserable with it." In 2015, when Scott was 13, Nancy took him to an assessment appointment with Edwards-Leeper. "She asked me about how I felt when I was younger—was I comfortable with my body? What did I tend to like or be interested in?," Scott recalled. He said that getting on testosterone took what felt like a long time. (He was on puberty blockers for about a year.) But he said he understood that Edwards-Leeper was making certain he had considered a range of questions—from how he would feel about possibly not being able to have biological kids to whether he was comfortable with certain hormonal effects, such as a deeper voice. Scott told Edwards-Leeper that he was pretty certain about what he wanted.

Scott told me that overall, being on testosterone made him feel better, though also a bit more into "adrenaline-junkie stuff" than before. (There had been a recent incident involving Scott taking Nancy's car for a spin despite not yet having his learner's permit.) When I asked him about top surgery, which he was hoping to have early in the spring, he got about as animated as I saw him during our lunch. "Oh, it's going to be so freeing," he said. "I can change in the locker room!" In April I checked in with Nancy, and she said in an email that the surgery had gone well: "He is SO happy not to have to wear a binder!"

Scott's assessment process centered mostly on the basic readiness questions Edwards-Leeper and Leibowitz are convinced should be asked of any young person considering hormones. But his was a relatively clear-cut case: He'd had unwavering gender dysphoria since early childhood, a lack of serious mental-health concerns, and a generally supportive family. For other gender-dysphoric young people, mental-health problems and family dynamics can complicate the transition process, though they are by no means, on their own, an indication that someone shouldn't transition.

I met Orion Foss at a vegetarian café in the Dennison Place neighborhood of Columbus. Orion is an expressive 18-year-old with big eyes who is where Scott Padberg may be in a couple of years. Orion's gender trajectory was a bit different, though. As a teenager, he identified as a lesbian and became involved in the local LGBTQ scene. He says that in 2014, when he was 14 years old and trans narratives were starting to show up more frequently on social media, he realized he was trans. He was also suffering from severe depression and anxiety at the time, which had led to self-harm issues, as well as what may have been an undiagnosed eating disorder. Orion believed that additional weight went straight to his hips and chest, accentuating his feminine features. At one point, he dipped down to 70 pounds.

A year or so after he realized he was trans, he told his mother, an ob-gyn, who took him to the THRIVE program at Nationwide, which had recently opened. (Leibowitz didn't work there yet.) Orion met with two clinicians for an eight-hour assessment. He told me he was "definitely intimidated," but if "you want to do something permanent to your body, you have to be absolutely positive that there's no other way of doing it."

At the time, Orion was initially upset that, because he was underage, THRIVE wouldn't put him on hormones without the consent of both parents (his father had signed off, but his mother had not). He started sobbing when he found out. But the THRIVE team made clear that it was going to help him get where he wanted to be. In the meantime, a THRIVE therapist, Lourdes Hill, would work with Orion to address his anxiety and depression.

Looking back, Orion sees the value of this process. "If I had been put on hormone therapy when I didn't have my identity settled, and who I was settled, and my emotions settled, it would have been crazy. 'Cause when I did start hormone therapy, hormones shoot your mood all around, and it's not exactly safe to just shoot hormones into someone that's not stable." He ended up seeing Hill for weekly appointments, talking about not only his gender-identity and mental-health issues, but a host of other subjects as well. "She weeded through every possible issue with me that she could get to," he said. "I'm glad she made me wait. And I'm glad the structure was there so I couldn't just throw myself into something that probably would have made me worse off."

Eventually, his mother, who was "very hesitant," and was refusing to sign the paperwork for him to start hormones, came around. The THRIVE team helped her come to grips with the fact that the child she had always known as her daughter was going to become her son. "Lourdes was the driving force in that," Orion told me in a follow-up email. "Spent a lot of time with me and my mother in therapy."

When he was finally able to begin the hormone treatments, Orion said, he "immediately felt this weight off my shoulders." His dosage was gradually increased and then, in May 2017, he got a double mastectomy. Orion's transition has clearly had a profoundly beneficial effect. It's changed the way he carries himself in the world. Before, "I would sit like this"—he slouched over—"and hide every possible female thing about me." Now, he said, he can sit up straight. He feels like himself.

Orion Foss worked with the clinicians at Ohio's THRIVE clinic on his mental health, his mother's concerns, and, eventually, his transition. (Matt Eich)

SOME PARENTS STRUGGLE with the challenges of raising a TGNC child, and they can make gender clinicians' already complicated jobs that much more complicated. Many, like Orion Foss's mother, have trouble accepting the idea of their child transitioning. She, at least, came around. In other cases, parents not only refuse to help their child receive treatment but physically abuse them or kick them out of the house. (Reliable numbers for trans young people specifically are hard to come by, but LGBTQ youth are 120 percent more likely than their straight or cisgender counterparts to experience a period of homelessness, according to a study by Chapin Hall, a research center at the University of Chicago.)

But progressive-minded parents can sometimes be a problem for their kids as well. Several of the clinicians I spoke with, including Nate Sharon, Laura Edwards-Leeper, and Scott Leibowitz, recounted new patients' arriving at their clinics, their parents having already developed detailed plans for them to transition. "I've

actually had patients with parents pressuring me to recommend their kids start hormones," Sharon said.

In these cases, the child might be capably navigating a liminal period of gender exploration; it's the parents who are having trouble not knowing whether their kid is a boy or a girl. As Sharon put it: "Everything's going great, but Mom's like, 'My transgender kid is going to commit suicide as soon as he starts puberty, and we need to start the hormones now.' And I'm like, 'Actually, your kid's just fine right now. And we want to leave it open to him, for him to decide that.' Don't put that in stone for this kid, you know?"

Suicide is the dark undercurrent of many discussions among parents of TGNC young people. Suicide and suicidal ideation are tragically common in the transgender community. An analysis conducted by the American Foundation for Suicide Prevention and the Williams Institute, published in 2014, found that 41 percent of trans respondents had attempted suicide; 4.6 percent of the overall U.S. population report having attempted suicide at least once. While the authors note that for methodological reasons 41 percent is likely an overestimate, it still points to a scarily high figure, and other research has consistently shown that trans people have elevated rates of suicidal ideation and suicide relative to cisgender people.

Scott Leibowitz, a psychiatrist who treats children and adolescents in Columbus, Ohio, is a proponent of comprehensive assessments for young people seeking to transition. (Matt Eich)

But the existence of a high suicide rate among trans people—a population facing high instances of homelessness, sexual assault, and discrimination—does not imply that it is common for young people to become suicidal if they aren't granted immediate access to puberty blockers or hormones. Parents and clinicians do need to make fraught decisions fairly quickly in certain situations. When severely dysphoric kids are approaching puberty, for instance, blockers can be a crucial tool to buy time, and sometimes there's a genuine rush to gain access to them, particularly in light of the waiting lists at many gender clinics. But the clinicians I interviewed said they rarely encounter situations in which immediate access to hormones is the difference between suicide and survival. Leibowitz noted that a relationship with a caring therapist may itself be an important prophylactic against suicidal ideation for TGNC youth: "Often for the first time having a medical or mental-health professional tell them that they are going to take them seriously and really listen to them and hear their story often helps them feel better than they've ever felt."

The conversations parents are having about gender-dysphoric children online aren't always so nuanced, however. In many of these conversations, parents who say they have questions about the pace of their child's transition, or whether gender dysphoria is permanent, are told they are playing games with their child's life. "Would you rather have a live daughter or a dead son?" is a common response to such questions. "This type of narrative takes an already fearful parent and makes them even more afraid, which is hardly the type of mind-set one would want a parent to be in when making a complex lifelong decision for their adolescent," Leibowitz said.

WHEN PARENTS DISCUSS the reasons they question their children's desire to transition, whether in online forums or in response to a journalist's questions, many mention "social contagion." These parents are worried that their kids are influenced by the gender-identity exploration they're seeing online and perhaps at school or in other social settings, rather than experiencing gender dysphoria.

In some cases, a child might be capably navigating a liminal period of gender exploration; it's the parents who are having trouble not knowing whether their kid is a boy or a girl.

Many trans advocates find the idea of social contagion silly or even offensive given the bullying, violence, and other abuse this population faces. They also point out that some parents simply might not *want* a trans kid—again, parental skepticism or rejection is a painfully common experience for trans young people. Michelle Forcier, a pediatrician who specializes in youth-gender issues in Rhode Island, said the trans adolescents she works with frequently tell her things like *No one's taking me seriously—my parents think this is a phase or a fad*.

But some anecdotal evidence suggests that social forces *can* play a role in a young person's gender questioning. "I've been seeing this more frequently," Laura Edwards-Leeper wrote in an email. Her young clients talk openly about peer

influence, saying things like *Oh, Steve is really trans, but Rachel is just doing it for attention*. Scott Padberg did exactly this when we met for lunch: He said there are kids in his school who claim to be trans but who he believes are not. "They all flaunt it around, like: 'I'm trans, I'm trans, I'm trans,'" he said. "They post it on social media."

I heard a similar story from a quirky 16-year-old theater kid who was going by the nickname Delta when we spoke. She lives outside Portland, Oregon, with her mother and father. A wave of gender-identity experimentation hit her social circle in 2013. Suddenly, it seemed, no one was cisgender anymore. Delta, who was 13 and homeschooled, soon announced to her parents that she was genderqueer, then nonbinary, and finally trans. Then she told them she wanted to go on testosterone. Her parents were skeptical, both because of the social influence they saw at work and because Delta had anxiety and depression, which they felt could be contributing to her distress. But when her mother, Jenny, sought out information, she found herself in online parenting groups where she was told that if she dragged her feet about Delta's transition, she was potentially endangering her daughter. "Any questioning brought down the hammer on you," she told me.

Delta's parents took her to see Edwards-Leeper. The psychologist didn't question her about being trans or close the door on her *eventually* starting hormones. Rather, she asked Delta a host of detailed questions about her life and mental health and family. Edwards-Leeper advised her to wait until she was a bit older to take steps toward a physical transition—as Delta recalled, she said something like "I acknowledge that you feel a certain way, but I think we should work on other stuff first, and then if you still feel this way later on in life, then I will help you with that."

"Other stuff" mostly meant her problems with anxiety and depression. Edwards-Leeper told Jenny and Delta that while Delta met the clinical threshold for gender dysphoria, a deliberate approach made the most sense in light of her mental-health issues.

Delta, a patient of Laura Edwards-Leeper who wanted to transition. Edwards-Leeper counseled her to take things slowly and to work on her co-occurring mental-health issues. Her gender dysphoria eventually lifted. (Matt Eich)

"At the time I was not happy that she told me that I should go and deal with mental stuff first," Delta said, "but I'm glad that she said that, because too many people are so gung ho and just like, 'You're trans, just go ahead,' even if they aren't—and then they end up making mistakes that they can't redo." Delta's gender dysphoria subsequently dissipated, though it's unclear why. She started taking antidepressants in December, which seem to be working. I asked Delta whether she thought her mental-health problems and identity questioning were linked. "They definitely were," she said. "Because once I actually started working on things, I got better and I didn't want anything to do with gender labels—I was fine with just being me and not being a specific thing."

It's imperative to remember that Delta's is a kind of story that can happen only in a place where trans people are accepted—and where parents, even skeptical ones like Jenny, are open-minded enough to take their kid to a clinician like Edwards-Leeper. In vast swaths of the United States, kids coming out as trans are much more likely to be met with hostility than with enhanced social status or recognition, and their parents are more likely to lack the willingness—or the resources—to find them care. But to deny the possibility of a connection between social influences and gender-identity exploration among adolescents would require ignoring a lot of what we know about the developing teenage brain—which is more susceptible to peer influence, more impulsive, and less adept at weighing long-term outcomes and consequences than fully developed adult brains—as well as individual stories like Delta's.

NOT EVERYONE AGREES about the importance of comprehensive assessments for transgender and gender-nonconforming youth. Within the small community of clinicians who work with TGNC young people, some have a reputation for being skeptical about the value of assessments. Johanna Olson-Kennedy, a physician who specializes in pediatric and adolescent medicine at Children's Hospital Los Angeles and who is the medical director of the Center for Transyouth Health and Development, is one of the most sought-out voices on these issues, and has significant differences with Edwards-Leeper and Leibowitz. In "Mental Health Disparities Among Transgender Youth: Rethinking the Role of

Professionals," a 2016 *JAMA Pediatrics* article, she wrote that "establishing a therapeutic relationship entails honesty and a sense of safety that can be compromised if young people believe that what they need and deserve (potentially blockers, hormones, or surgery) can be denied them according to the information they provide to the therapist."

One clinician said her trans clients talk openly about peer influence, saying things like *Oh, Steve is really trans, but Rachel is just doing it for attention.*

This view is informed by the fact that Olson-Kennedy is not convinced that mental-health assessments lead to better outcomes. "We don't actually have data on whether psychological assessments lower regret rates," she told me. She believes that therapy can be helpful for many TGNC young people, but she opposes mandating mental-health assessments for all kids seeking to transition. As she put it when we talked, "I don't send someone to a therapist when I'm going to start them on insulin." Of course, gender dysphoria is listed in the *DSM-5*; juvenile diabetes is not.

One recent study co-authored by Olson-Kennedy, published in the *Journal of Adolescent Health*, showed that her clinic is giving cross-sex hormones to kids as young as 12. This presses against the boundaries of the Endocrine Society's guidelines, which state that while "there may be compelling reasons to initiate sex hormone treatment prior to age 16 years ... there is minimal published experience treating prior to 13.5 to 14 years of age."

If you see gender-dysphoric 13- and 14-year-olds not as young people with a condition that may or may not indicate a permanent identity, but as *trans kids*, full stop, it makes sense to want to grant them access to transition resources as quickly as possible. Olson-Kennedy said that the majority of the patients she sees do need that access. She said she sees a small number of patients who desist or later regret transitioning; those patients, in her opinion, shouldn't dictate the care of others.

She would like to see a radical reshaping of care for TGNC young people. "The way that the care has been organized is around assuring the certainty and decreasing the discomfort of the professionals (usually cisgender) who determine if the young people are ready or not," she told me. "And that's a broken model."

HOW BEST TO SUPPORT TGNC KIDS is a whiplash-inducing subject. To understand even just the small set of stories I encountered in my reporting—stories involving relatively privileged white kids with caring, involved families, none of which is necessarily the case for all TGNC young people in the United States—requires keeping several seemingly conflicting claims in mind. Some teenagers, in the years ahead, are going to rush into physically transitioning and may regret it. Other teens will be prevented from accessing hormones and will suffer great anguish as a result. Along the way, a heartbreaking number of trans and gender-nonconforming teens will be bullied and ostracized and will even end their own lives.

Some LGBTQ advocates have called for gender dysphoria to be removed from the *DSM-5*, arguing that its inclusion pathologizes being trans. But gender dysphoria, as science currently understands it, is a painful condition that requires treatment to be alleviated. Given the diversity of outcomes among kids who experience dysphoria at one time or another, it's hard to imagine a system without a standardized, comprehensive diagnostic protocol, one designed to maximize good outcomes.

Experiencing gender dysphoria isn't the same as experiencing anxiety or depression or psychological ailments, of course. But in certain ways it is similar: As with other psychiatric conditions, some people experience dysphoria more acutely than others; its severity can wax and wane within an individual based on a variety of factors; it is in many cases intimately tied to an individual's social and familial life. For some people, it will pass; for others, it can be resolved without medical interventions; for still others, only the most thorough treatment available will relieve immense suffering. We recognize that there is no one-size-fits-all approach

to treating anxiety or depression, and a strong case can be made that the same logic should prevail with gender dysphoria.

Perhaps a first step is to recognize detransitioners and desisters as being on the same "side" as happily transitioned trans people. Members of each of these groups have experienced gender dysphoria at some point, and all have a right to compassionate, comprehensive care, whether or not that includes hormones or surgery. "The detransitioner is probably just as scarred by the system as the transitioner who didn't have access to transition," Leibowitz told me. The best way to build a system that fails fewer people is to acknowledge the staggering complexity of gender dysphoria—and to acknowledge just how early we are in the process of understanding it.

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ABOUT THE AUTHOR

JESSE SINGAL is a contributing writer at *New York* magazine.

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