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CLERK OF THE DOUGLAS COUNTY DISTRICT COURT
CASE NUMBER: DG-2026-CV-000112
PII COMPLIANT

EXHIBIT 3

IN THE SEVENTH JUDICIAL DISTRICT
DOUGLAS COUNTY DISTRICT COURT
CIVIL DEPARTMENT

DANIEL DOE and MATTHEW MOE,

Plaintiffs,

v.

STATE OF KANSAS, *ex rel* KRIS
KOBACH, Attorney General; KANSAS
DEPARTMENT OF REVENUE, KANSAS
DIVISION OF VEHICLES; DEANN
WILLIAMS, Director of Vehicles,
Department of Revenue, in her official
capacity; MARK BURGHART, Secretary of
Kansas Department of Revenue, in his official
capacity; KANSAS DEPARTMENT OF
ADMINISTRATION; and ADAM PROFFIT,
Secretary of Department of Administration, in
his official capacity,

Defendants.

Case No. _____

Div. No. 7

EXPERT DECLARATION OF ANGELA L. TURPIN, MD

EXPERT DECLARATION OF ANGELA L. TURPIN, MD

I, Angela L. Turpin, hereby state as follows:

INTRODUCTION

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation. I am over 18 years old, of sound mind, and in all respects competent to testify. I am providing this declaration in my personal capacity.

2. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

3. In preparing this declaration, I reviewed Kansas Senate Bill No. 244 (“SB 244”). In addition to this legislation and the materials cited herein, I rely on my years of education, experience, and research, as summarized in my curriculum vitae (CV) (**Exhibit A**), in forming my opinions. The materials I relied upon in preparing this declaration are the same kinds of materials that experts in my field of study regularly rely upon when forming opinions. A bibliography is attached as **Exhibit B**. I may wish to supplement these opinions or the bases for them as a result of new scientific research or publications or in response to statements and issues that may arise in my areas of expertise.

4. I am a pediatric endocrinologist and assistant professor of pediatrics at the University of Missouri-Kansas City School of Medicine. I am also the medical director for the Gender Pathways Services Clinic at Children’s Mercy Kansas City. I submit this declaration to describe gender identity, gender dysphoria, the impact of incongruent driver’s licenses on gender dysphoria, and the impact of restricted restroom access on both gender dysphoria and physical health.

SUMMARY OF OPINIONS

5. Management and treatment of gender dysphoria require the ability to live in accordance with one's gender identity in all aspects of life. This includes the ability to change one's legal name and gender marker on official legal documents such as driver's licenses and use the restrooms that align with one's gender identity. When transgender people are unable to use identity documents or restrooms that reflect their gender, they are less likely to succeed in education and employment, more likely to withdraw from society, are more frequently harassed, and often feel like they cannot safely use public spaces.

6. SB 244 will cause mental and physical harm to transgender individuals and individuals with gender dysphoria in Kansas because it will exacerbate gender dysphoria by impeding their ability to socially transition or live as transgender individuals and may expose them to risks of harassment and physical harm by revealing their transgender status.

BACKGROUND AND QUALIFICATIONS

7. I am a clinician and medical educator at Children's Mercy in Kansas City. I serve as medical director for the Gender Pathways Services Clinic that provides gender affirming care in Kansas and the surrounding states. I am also an assistant professor of pediatrics at the University of Missouri-Kansas City School of Medicine.

8. I attended the University of Missouri, Kansas City's 6-year combined undergraduate/medical school program. I received my bachelor of arts in biology in 1997 and doctorate of medicine in 1999. I completed a 3-year residency in pediatrics in 2002 and went on to complete a 3-year fellowship in pediatric endocrinology in 2005, both at Children's Mercy.

9. I have held active licenses to practice medicine in both Missouri and Kansas since 2001 and 2002 respectively. I am currently board certified in Pediatric Endocrinology.

10. I have published scholarly articles and presented on a number of topics, including the care of youth with gender dysphoria, issues specific to rural populations, the prevalence of differences of sex development, and growth charts.

11. As an assistant professor of pediatrics, my teaching duties include formal and informal instruction of medical students, residents, and fellows on subjects in the field of pediatric endocrinology. Formal instruction includes lectures on the core educational topics in endocrinology as outlined by the American Board of Pediatrics. My duties include mentoring of weekly case conferences within the division of endocrinology, as well as endocrine-related hospital-wide professor rounds, weekly informal education in the outpatient clinic setting, and inpatient consultations for one week each quarter.

12. My current role as medical director of the Gender Pathways Services (GPS) Clinic at Children's Mercy includes overseeing all processes and procedures related to the medical care received in the clinic as well as working with the GPS behavioral health director and other team members to coordinate care and staffing. I also provide medical education to medical students, residents, and fellows during interactions with patients in clinic and through formal lectures and instruction.

13. I have extensive experience as a pediatric endocrinologist, including the treatment of endocrine conditions such as diabetes, thyroid disorders, puberty related disorders (including precocious/delayed puberty), disorders of sex development, adrenal disorders, pituitary disorders, growth disorders, and hypoglycemia, as well as gender dysphoria.

14. I have been treating patients with gender dysphoria since 2014 in the GPS Clinic at Children's Mercy and have served as the medical director of the clinic for the past 3 years. I estimate that over the past 12 years, I have treated 350 adolescent or young adult patients with

gender dysphoria, and participated in or overseen the care of many more. Adolescents who begin medication for gender dysphoria at our institution typically continue with us until transitioning to adult care after age 22.

15. I have previously testified as an expert witness in *Loe v. Kansas*, Case No. DG-2025-CV-000241 (Douglas County District Court).

16. I am being compensated for my time preparing this declaration. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

EXPERT OPINIONS

S.B. 244 Does Not Reflect Medical Understandings of Sex and Gender

17. In my medical opinion, SB 244 reflects a misunderstanding of the biological complexity of sex and the clinical factors physicians consider when evaluating sex characteristics. The bill adopts rigid, categorical definitions that do not account for the well-recognized variation in chromosomal patterns, gonadal development, hormonal profiles, internal reproductive anatomy, and external genitalia. As a result, the statute would not produce consistency and uniformity in physical characteristics of people designated as having the same sex.

18. From a medical and scientific standpoint, defining “female” exclusively as an individual “whose biological reproductive system is developed to produce ova” and “male” exclusively as an individual “whose biological reproductive system is developed to fertilize the ova of a female” is imprecise and medically illogical for several reasons.

19. First, these definitions reduce sex to reproductive capacity. In clinical medicine, sex is understood as a constellation of characteristics that include chromosomes, gonads, internal reproductive organs, external genitalia, hormonal milieu, and secondary sex characteristics. These

components do not always align uniformly, and reproductive capacity is neither present in all individuals nor determinative of sex classification in medical practice.

20. Second, many individuals who are recognized and classified as female do not have the capacity to produce ova. This includes prepubertal girls, postmenopausal women, women with primary ovarian insufficiency, women who have undergone oophorectomy for cancer or other medical indications, and women with certain congenital conditions affecting ovarian development. Likewise, many individuals recognized as male do not have the capacity to produce sperm capable of fertilizing ova, including prepubertal boys, men with infertility, men who have undergone orchiectomy, men with genetic or endocrine conditions affecting spermatogenesis, and elderly men. Medical classification of sex does not change based on fertility status.

21. Third, the phrase “developed to produce ova” or “developed to fertilize ova” lacks clinical precision. Developmental biology is complex, and reproductive organs may be present but nonfunctional, partially developed, surgically altered, or hormonally suppressed. The mere theoretical design or typical function of an organ system does not determine a person’s sex classification in clinical practice.

22. Fourth, these definitions fail to account for individuals with differences (or disorders) of sex development. In clinical practice, I treat and evaluate individuals with differences (or disorders) of sex development (DSDs), sometimes referred to as intersex traits. For example, individuals with complete androgen insensitivity syndrome may have XY chromosomes and internal testes but develop typical female external genitalia and are raised as girls. Individuals with congenital adrenal hyperplasia may have XX chromosomes and ovaries but present with varying degrees of genital virilization including an enlarged clitoris and labial fusion. Other individuals may have mosaic chromosomal patterns (e.g., XX/XY) or gonadal development that does not

conform to typical binary definitions including ovotestes in which both ovarian and testicular tissue are present in the same individual. A framework based solely on reproductive potential cannot coherently classify such individuals.

23. Fifth, tying legal sex definitions exclusively to reproductive function is inconsistent with how sex is recorded and used in medical records. In clinical settings, sex designation serves multiple purposes, including guiding preventive care, screening, and treatment decisions. Those determinations are based on a patient's anatomy, hormonal status, and medical history—not on an abstract or theoretical reproductive capacity.

24. Finally, reproductive capacity changes over the lifespan and may be altered by disease, injury, aging, or medical treatment. A definition of sex that would shift with fertility status is not medically sound, as sex classification in health care does not fluctuate based on a person's current ability to reproduce.

25. For these reasons, defining "female" and "male" solely by reference to reproductive system capacity is overly simplistic, inconsistent with established medical science, and incapable of accurately capturing the biological diversity encountered in clinical practice.

Gender Identity and Gender Dysphoria

26. Gender identity is a person's deeply felt, inherent sense of their gender. Gender identity is a core aspect of human development. All individuals have a gender identity, and an individual's understanding or articulation of that identity may evolve over time. Gender identity is immutable and cannot be voluntarily altered, and it is considered unethical as well as harmful to try to change someone's gender identity.

27. Sex is typically assigned or designated at birth based on observation of external genitalia. In most cases, medical providers do not conduct chromosomal analysis, hormonal testing,

or imaging of internal reproductive anatomy when assigning sex at birth unless there is a specific medical indication to do so.

28. For most individuals, gender identity aligns with the sex assigned at birth. These individuals are referred to as cisgender.

29. Transgender individuals have a gender identity that differs from the sex assigned to them at birth.

30. In medical and scientific contexts, the terms “sex assigned at birth” or “sex designated at birth” are preferred over “biological sex” because they are more precise. Human sex characteristics include multiple components—chromosomes, gonads, internal reproductive anatomy, external genitalia, secondary sex characteristics, and hormonal profiles—which do not always align in a binary or uniform manner.¹

31. Transgender individuals have a gender identity that is not congruent with the sex assigned at birth or with certain other sex characteristics.

32. Some transgender individuals experience gender dysphoria, which is the clinically significant distress that may result from the incongruence between one’s gender identity and sex assigned at birth or associated physical characteristics. Gender dysphoria may manifest at any age.

33. Gender dysphoria is a recognized diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*, published by the American Psychiatric

¹See Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, Rosenthal SM, Safer JD, Tangpricha V, TSjoen GG. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab.* 2017 Nov 1;102(11):3869-3903. doi: 10.1210/jc.2017-01658. Erratum in: *J Clin Endocrinol Metab.* 2018 Feb 1;103(2):699. doi: 10.1210/jc.2017-02548. Erratum in: *J Clin Endocrinol Metab.* 2018 Jul 1;103(7):2758-2759. doi: 10.1210/jc.2018-01268. PMID: 28945902.

Association. The diagnostic criteria include a marked incongruence between one's experienced or expressed gender and assigned sex lasting at least six months and associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

34. Being transgender is not, in itself, a mental health disorder. However, untreated gender dysphoria—as well as stigma, discrimination, and harassment—can contribute to significant anxiety, depression, and suicidality.

35. Major medical and mental health organizations in the United States support access to evidence-based, age-appropriate, and individualized gender-affirming care. These organizations include the American Medical Association, the American Academy of Pediatrics, the American Psychological Association, the Endocrine Society, the Pediatric Endocrine Society, the Society for Adolescent Health and Medicine, the World Medical Association, and the World Health Organization.

36. Social transition is an important and medically recognized component of gender affirmation for many transgender individuals. Social transition may include changes in name, pronouns, clothing, hairstyle, manner of presentation, and legal documentation. For some individuals, social transition is sufficient to relieve gender dysphoria; for others, it is an essential first step in treatment.

37. Some transgender individuals seek medical treatment to better align their physical characteristics with their gender identity. For transgender men (individuals assigned female at birth who identify as male), treatment may include testosterone therapy, which induces changes such as deepening of the voice, increased facial and body hair, and redistribution of muscle and fat. For transgender women (individuals assigned male at birth who identify as female), treatment may

include estrogen and androgen-blocking medications, which promotes changes such as breast development, decreased body hair, and skin softening.

38. Some transgender adults pursue surgical interventions as part of treatment for gender dysphoria. These procedures may modify primary or secondary sex characteristics.

39. Because of natural variation in human anatomy and secondary sex characteristics—and because some individuals undergo medical treatment to align their bodies with their gender identity—it is not possible to determine whether a person is transgender or cisgender based solely on appearance.

40. Being perceived or treated inconsistently with one's gender identity, including being misgendered, can exacerbate gender dysphoria and psychological distress.

41. As explained below, policies that prevent transgender individuals from using restrooms consistent with their gender identity or from obtaining accurate identity documents interfere with medically recognized treatment for gender dysphoria and result in significant psychological and physical harm.

The Impact of Being Unable to Use a Restroom Congruent with Gender Identity

42. In the United States, most public multi-user restrooms are separated by sex or gender designation (e.g., men's and women's facilities), unlike most other shared public spaces. When a transgender individual is prohibited from using facilities consistent with their gender identity, the exclusion produces foreseeable and clinically significant mental and physical health consequences.

43. From a medical perspective, denying access to facilities consistent with a person's gender identity constitutes a form of social non-affirmation. Social affirmation is a well-recognized component of treatment for gender dysphoria and includes the ability to live and function in society

in accordance with one's gender identity. Exclusion from restrooms aligned with one's gender identity undermines this process and can exacerbate gender dysphoria.

44. When transgender individuals are required to use facilities inconsistent with their gender identity—or are segregated into single-user facilities not required of their peers—the message conveyed is that their gender identity is invalid or that they are fundamentally “other.” This type of stigmatizing treatment is associated with significant psychological harm. My patients subjected to such exclusion commonly report increased feelings of rejection, isolation, shame, and social stigma. Not being able to use the restroom is one of the most common reasons my patients cite for dropping out of school or not obtaining employment. This creates the situation of being frozen in their lives and unable to participate in social life, education, or employment. These experiences are associated with elevated rates of anxiety, depressive symptoms, and suicidal ideation.

45. Research in minority stress demonstrates that repeated exposure to discrimination has cumulative psychological effects, particularly when it involves identity-based stigma. Multiple studies over the past decade have demonstrated the adverse effects that restroom restrictions have on transgender individuals. A 2016 study assessing housing and bathroom restrictions for adults on college and university campuses found that restrictions resulted in increased suicidality even after controlling for interpersonal victimization by students and teachers. Another study from the Journal of Adolescent Health published in 2021 noted that 58% of trans and non-binary youth sampled reported being prevented or discouraged from using a restroom that aligned with their gender identity. Of those youth who experienced restroom discrimination 85% reported depressive mood and 60% seriously considered suicide with 1 in 3 reporting a past-year suicide attempt. Increased suicidality and suicide attempt was found even

after adjusting for demographic variables and general discrimination due to one's gender identity indicating that restroom discrimination alone significantly increased odds of depressed mood, suicidality, and suicide attempts. Most recently an article published in 2025 in the International Journal of Transgender Health examined restroom access in a cross-sectional survey of 12,596 transgender and non-binary individuals aged 13-24 years. Public restroom avoidance over the past year was reported by 73%. Those who avoided restrooms reported numerous physical health problems related to restroom avoidance including urinary tract infections and kidney infection. Additionally, restroom avoidance, either sometime or always, was associated with higher odds of anxiety, depression, suicidality, and attempting suicide at least once in the previous year among the survey subjects.

46. Most transgender individuals begin using restrooms consistent with their gender identity while undertaking other aspects of social transition, such as changes in name, pronouns, clothing, hairstyle, and manner of presentation. At that stage, requiring a transgender individual to use facilities inconsistent with their lived gender often results in forced disclosure of their transgender status. This disclosure may occur because the individual's gender presentation no longer aligns with the designation of the facility they are compelled to use, thereby drawing attention and scrutiny.

47. Forced disclosure has two primary medical and psychosocial consequences. First, it generates acute psychological distress associated with the loss of privacy regarding deeply personal information. Patients with gender dysphoria are entitled to confidentiality regarding their diagnosis and treatment. Being involuntarily "outed" can significantly worsen anxiety and dysphoria. Second, disclosure of transgender identity increases the risk of discrimination, harassment, bullying, and physical victimization. Transgender individuals already experience

disproportionately high rates of restroom-related harassment when perceived as not conforming to gendered expectations. Policies that compel use of incongruent facilities heighten both the risk of actual victimization and the chronic stress associated with anticipating such harm. Research published in the journal Pediatrics in 2019 looked at prevalence of sexual assault among transgender and non-binary students using restrooms and locker rooms at school. The study found that youth who were restricted to restrooms and locker rooms based on sex assigned at birth were more likely to experience sexual assault compared to those without restrictions except for non-binary youth assigned male at birth. Furthermore, a July 2017 research brief conducted by the Police Foundation, an independent and non-partisan police research organization, assessed the concern that men, under the guise of being women or transgender, entered women's restrooms to commit sexual assault or otherwise victimize women. Their research reviewed reports of sexual assaults to have occurred in places of public accommodation in Atlanta, Georgia; Dallas, Texas; Miami Beach/Miami Gardens in Miami-Dad County, Florida; and Tucson, Arizona and found no evidence supporting men committing sexual assault while dressing as women or expressing a transgender identity. The same findings are noted in a more recent review entitled "Trans Women and Public Restrooms: The Legal Discourse and its Violence" published in *Frontiers in Sociology* in 2021.

48. Exclusion of transgender people from facilities accessible to their peers also communicates to others that transgender individuals are unfit to share common spaces, reinforcing stigma and increasing the likelihood of mistreatment. Even in the absence of overt acts of harassment, the persistent anticipation of discrimination produces clinically significant stress responses, which are known to adversely affect mental and physical health over time.

49. To avoid misgendering, harassment, or forced disclosure, many transgender individuals restrict or entirely avoid restroom use in public settings. This avoidance behavior has measurable health consequences. Some individuals limit fluid intake to reduce the need to urinate, increasing the risk of dehydration and associated complications. Others delay urination for prolonged periods, which can contribute to urinary tract infections, bladder dysfunction, and, in severe cases, kidney complications. Individuals may also restrict food intake to avoid the need for bowel movements, resulting in constipation, gastrointestinal distress, and nutritional concerns. These behaviors are not uncommon among my transgender patients facing restroom access barriers and represent foreseeable and preventable medical harms.

50. For example, a transgender girl in my clinic developed orthostatic hypotension and fainting due to dehydration, because she was restricting fluids so as not to have to use the restroom at school. A transgender boy in our clinic developed urinary tract infections from restroom avoidance and had to switch to online school which he found isolating and depressing. There are additional case reports of such incidences in the medical literature including a 17-year-old transgender boy who required an inpatient hospital admission for pyelonephritis, severe constipation, and weight loss secondary to bathroom avoidance at school. On a broader scale a study in the Journal of Sexual Medicine from April 2025 analyzed existing literature on the health effects of urinary retention and bathroom avoidance. The literature review identified 15 studies meeting their inclusion criteria and found that restroom avoidance rates ranged from 60-90% among transgender individuals with fear of harassment, violence, and non-inclusive restroom policies cited as primary reasons. These concerns adversely impacted mental health across the studies. Five studies within the review reported a significant association between restroom avoidance and urinary tract infection prevalence in transgender individuals.

51. In sum, prohibiting transgender individuals from using restrooms consistent with their gender identity interferes with medically recognized treatment for gender dysphoria, increases psychological distress, elevates risk of discrimination and victimization, and contributes to adverse physical health outcomes. From a medical standpoint, such restrictions are harmful and inconsistent with accepted standards of gender-affirming care.

The Impact of Being Unable to Obtain Identity Documents Consistent with Gender Identity

52. Transgender individuals who are diagnosed with gender dysphoria may, as part of a medically indicated and prescribed treatment plan, pursue changes to their legal name and gender marker on official identity documents, including but not limited to a driver's license and birth certificate. For many patients, aligning legal documentation with their gender identity is a clinically recognized component of gender-affirming care.

53. Updating identity documents to reflect a patient's affirmed gender has substantial and well-documented health benefits for individuals with gender dysphoria. Peer-reviewed research demonstrates that legal gender affirmation is significantly associated with lower levels of depression, anxiety, somatization, overall psychiatric distress, and distress related to gender-based mistreatment. These findings are consistent with the established understanding that gender affirmation reduces the psychological burden associated with gender dysphoria. Accurate identity documents also promote identity integration, which is an important component of psychological well-being. A 2020 a cross-sectional study of 22,286 survey participants published in Lancet Public Health found that respondents for whom all IDs reflected the appropriate gender identity had lower prevalence of serious psychological stress including suicide ideation and suicide planning after adjusting for potential confounders. A more recent meta-analysis published in

Social Science Medicine in 2025 on the health effects of recognition of gender identity on legal identity documents included 24 studies in its review. In the meta-analysis legal recognition of gender identity was associated with less suicidal ideation and psychological stress. It may also reduce anticipated discrimination, increase healthcare utilization, reduce gonadectomies, and improve socioeconomic status.

54. The inability to obtain or maintain identity documents that accurately reflect one's gender identity can exacerbate gender dysphoria by reinforcing a persistent incongruence between one's affirmed gender and official recognition. This lack of recognition may convey to the individual that their gender identity is less valid or less deserving of respect than that of cisgender individuals. The harm is particularly acute for patients who currently possess accurate documentation and who would be forced, suddenly, to disclose their transgender status to employers, colleagues, or members of their community because they have lost access to that documentation.

55. Misgendering—referring to a transgender person by incorrect pronouns or by a prior name—has been shown to cause significant psychological harm and may exacerbate gender dysphoria. Empirical studies have found that consistent use of a person's chosen name and correct pronouns is associated with substantial increases in depressive symptoms, suicidal ideation, and suicide attempts. When transgender individuals can present identity documents that accurately reflect their gender identity and expression in situations requiring identification, they are less likely to experience misgendering and its associated adverse health outcomes.

56. Accurate government-issued identification is frequently required to access essential health-promoting resources, including health care, housing, education, and employment. Such documentation is also necessary for travel, background checks, public benefits, and other critical

structural systems. In addition, identification is routinely required for ordinary activities of daily living, including financial transactions, age verification, and participation in civic and social life.

57. When the gender marker on the document does not align with the individual's appearance or affirmed gender, it can prompt intrusive questioning, public scrutiny, disbelief, or refusal of service.

58. Transgender individuals who lack identity documents consistent with their gender identity often avoid situations in which such documentation must be presented, to reduce the risk of being misgendered, outed as transgender, or subjected to discrimination. The anticipation of stigma and adverse treatment can result in avoidance behaviors that negatively affect both mental and physical health. Avoidance as a coping mechanism may provide short-term protection but contributes to long-term psychosocial stress. For example, we have had numerous young adults in our clinic who are not participating in education or employment because they cannot access an ID with the correct gender marker. The thought of being forced to out themselves has them fearing violence and discrimination. One young adult is very afraid of having to show police her ID in a simple traffic stop and so has chosen not to drive at all. However, this has made it difficult for her to socialize which has made her anxiety and depression worse. I just saw a patient last month who is devastated that her driver's license will revert back to a male gender marker. She is getting ready to graduate from college with dual degrees. Instead of being able to celebrate this wonderful accomplishment she is concerned that she will face discrimination in hiring or from coworkers if she is forced to out herself because of the need to show legal identification to gain employment.

59. In the Gender Pathways Clinic, we provide letters requesting changes in legal identification to accurately reflect gender identity. I have seen first-hand that having a legal ID that reflects one's gender identity markedly improves mental health in addition to opening doors

to opportunities in education and employment. Having the correct gender marker places the focus on advancing one's life rather than trying to hide in the shadows. This can be seen by what patients are able to attain in higher education or as they enter the work force. I frequently see higher achievement and workplace promotions in individuals who are accepted by their peers and coworkers as their gender identity when supported by their legal identification. I have also had patients report being less likely to be singled out for additional screening at airport security when their legal identification aligns with their gender presentation.

60. For transgender patients undergoing medically prescribed treatment for gender dysphoria, presenting identity documents that do not correspond to their gender presentation—an integral component of their treatment—forces them into an untenable choice: either avoid using necessary identification or repeatedly disclose private medical information. From a medical and ethical standpoint, this is inappropriate. Patients are entitled to privacy regarding their medical diagnoses and treatment, and requiring disclosure as a condition of using identification documents undermines accepted principles of patient autonomy, confidentiality, and standard medical care.

CONCLUSION

61. As a physician and pediatric endocrinologist with 25 years of experience and over a decade of experience caring for people with gender dysphoria, I can attest to the medical necessity of access to accurate identity documents like driver's licenses and the ability to use restrooms that are consistent with transgender individuals' gender identity.

62. If transgender individuals in Kansas are unable to obtain driver's licenses with gender markers consistent with their gender identity, it is my expert opinion that such individuals are more likely to experience exacerbated gender dysphoria and diminished psychological well-

being, as well as decreased access to educational, employment, and housing opportunities, as well as increased likelihood of harassment and violence.

63. If transgender individuals in Kansas are required to use the restrooms associated with the sex assigned at birth, it is my expert opinion that such individuals are more likely to experience exacerbated gender dysphoria and diminished psychological well-being, as well as decreased access to educational, employment, and housing opportunities, and increased likelihood of harassment and violence. Individuals who avoid using the restroom entirely are more likely to experience negative physical consequences, including dehydration, urinary tract infection, bladder dysfunction, hydronephrosis with potential for permanent kidney damage, constipation, and malnutrition.

I declare under penalty of perjury under the laws of the state of Kansas that the foregoing is true and correct.

Executed on 2/26/20 

ANGELA L. TURPIN, MD

EXHIBIT A

EXHIBIT A

Curriculum Vitae

Angela L. Turpin, MD

Office Address

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Kansas City, MO 64111
(816) 960-8892
Email: aturpin@cmh.edu

Professional Experience

Pediatric Endocrinologist 2005-present
Assistant Professor
Children's Mercy Hospital
Kansas City, MO

General Pediatrician 2002-2005
Rapid Care Clinic
Children's Mercy Hospital
Kansas City, MO

Fellow, Pediatric Endocrinology 2002-2005
Children's Mercy Hospital
Kansas City, MO

Resident, General Pediatrics 1999-2002
Children's Mercy Hospital
Kansas City, MO

Education

University of Missouri-Kansas City 1995-1999
School of Medicine
Degree: M.D.

University of Missouri-Kansas City 1993-1995
Degree: B.A. Biology

Certification and Examinations

Diplomate, American Board of Pediatrics, Pediatric Endocrinology, 2007

Diplomate, American Board of Pediatrics, 2002

USMLE I, II passed

USMLE III passed

Medical Licensure

Missouri, 2001 (# 2001008554)

Kansas, 2002 (#04-29941)

Professional Affiliations

American Academy of Pediatrics

American Diabetes Association

Pediatric Endocrine Society

Honors and Awards

Honors Hospital Team Experience, 1994

Honors in Pediatrics, 1998

Scholarship recipient to attend the Advanced Postgraduate Course on Growth and Growth Disorders in Stockholm, Sweden, 2005

Quality Improvement Poster Session 3rd place – Depression Screening in Type 1 Diabetes, Children's Mercy Hospital, Kansas City, MO, 2013.

Golden Apple Mentor Award, 2016

Golden Apple Mentor Award, 2021

Mentoring Achievement Award, 2022

Advocacy Achievement Award, 2023

Professional Activities

Member of Recruiting Committee

Children's Mercy Residency Program, 2000-2002

American Diabetes Association Children's Summer Camp

Camp Physician, 2000-2002

Medical Director, 2003-2016

Member of the Juvenile Diabetes Research Foundation Board of Directors – Kansas City Chapter, 2005-2012

Co-founder of the Children's Mercy High Risk Diabetes Clinic and Cystic Fibrosis Related Diabetes Clinic, 2004

Director of Clinical Services for the Children's Mercy Diabetes Center, 2005 – 2009

Medical Director of the Children's Diabetes Center, 2009 - 2016

Member of the Task Force Committee for Medical Student Curriculum Development Children's Mercy Hospital, 2005

Member of the Medical Student Education Committee

Children's Mercy Hospital, 2006 to 2007

Member of the Smiths Medical Physician Advisory Board for insulin pump therapy

Smiths Medical, 2007
University of Missouri – Kansas City School of Medicine Year 1 and 2 Pediatric Docent,
2007 to 2009
University of Kansas School of Medicine Year 2 Medical Student Preceptor 2007 - 2009
Member of the American Diabetes Association Board of Directors- Kansas City, 2009 -
2016, Board President, 2010 to 2014.
Member of Transition Committee
Children’s Mercy Hospital, 2012 - 2014
Director of Gender Pathways Services, 2023-present

Research

Effects of Letrozole on Skeletal Maturation in Females
Advisors: Jill Jacobson, MD and Jadranka Popovic, MD
Dept. of Pediatric Endocrinology, Children’s Mercy Hospital

Histamine Responsiveness in Patients with McCune Albright Syndrome
Advisor: Jill Jacobson, MD
Dept. of Pediatric Endocrinology, Children’s Mercy Hospital

Type 1 Diabetes prevention: TrialNet
Subinvestigator on the following studies: Natural history, NIP, Oral Insulin,
ATG

Grants

Katherine B. Richardson Foundation - \$10,000 grant awarded October 2003, Histamine
Responsiveness in Patients with McCune Albright Syndrome.

Publications

“Allergic manifestations and cutaneous histamine responses in patients with McCune Albright
syndrome.” Jacobson JD, Turpin AL, Sands SA. World Allergy Organ J. 2013 May 1;6(1):9.

“Frequency of mealtime insulin bolus predicts glycated hemoglobin in youths with type 1
diabetes.” Patton SR1, DeLurgio SA, Fridlington A, Cohoon C, Turpin AL, Clements MA.
Diabetes Technol Ther. 2014 Aug;16(8):519-23.

“Gender-Affirming Care in the Midwest: Reaching Rural Populations.” Poquiz J, Moser CN,
Grimstad F, Boman K, Sonnevile SA, Turpin A, Egan AM. Journal of Rural Mental Health.
2021, Vol. 45, No. 2, 121-128.

“Prevalence of Intersex/Differences in Sex Development and Primary Gonadal Insufficiency in a
Pediatric Transgender Population.” Randhawa H, Knoll M, McPhaul M, Dileepan K,
McDonough R, Turpin A, Jacobson D. Transgender Health 2024 Dec 16;9(6):544-552.

Book Chapters

“Fluids, Electrolytes, and Metabolism” chapter co-author. Lange Q and A: Pediatrics 7th Edition.
2010.

Presentations – International and National

“Effects of Letrozole on Skeletal Maturation in Females,” oral presentation at the Bone and Growth Plate Symposium in conjunction with the European Society for Pediatric Endocrinology. Basel, Switzerland. August 2004.

“Histamine Responsiveness in Patients with McCune-Albright Syndrome,” poster presentation at the 7th Joint Meeting of LWPES/ESPE. Lyon, France. September 21-24, 2005.

“Effects of Letrozole on Skeletal Maturation in Females,” oral presentation at ENDO 2004; the Endocrine Society’s 86th Annual Meeting. New Orleans, LA. June 16-19, 2004.

“Histamine Responsiveness in Patients with McCune-Albright Syndrome,” poster presentation at ENDO 2005; the Endocrine Society’s 87th Annual Meeting. San Diego, CA. June 4-7, 2005.

“Knowledge, Attitude and Practice regarding the use of Lantus® in children with type 1 Diabetes Mellitus at times of insulin pump malfunction” poster presentation at ADA 2013; American Diabetes Association 73rd Scientific Sessions. Chicago, IL. June 21-25, 2013.

“Transgender Youth and Eating Disorders,” oral presentation at the National Transgender Health Summit 2017. Oakland, CA. November 10-12, 2017.

“Challenges in Providing Rural Transgender Care,” roundtable discussion at the National Transgender Health Summit 2017. Oakland, CA. November 10-12, 2017.

“Establishing new growth charts in Transgender and Gender Non-binary Adolescents on standard gender-affirming therapy,” poster presentation at ENDO 2018; the Endocrine Society’s 100th Annual Meeting. Chicago IL. March 17-20, 2018.

Presentations – Regional and Local

“Effects of Letrozole on Skeletal Maturation in Females,” oral presentation at Kansas, Nebraska, and Missouri Society for Pediatric Endocrinology Annual Meeting. Kansas City, MO. October 21, 2004.

“Pediatric Thyroid,” core lecture presentation to residents at Children’s Mercy Hospital February 2004.

“Pediatric Endocrinology Overview,” core lecture presentation to University of Missouri – Kansas City medical students. Lecture given monthly.

“Endocrine Emergencies and DKA,” lecture given to Section of Pediatric Emergency Medicine at Children’s Mercy Hospital. February 2005.

“Adolescent Issues in Type I Diabetes,” lecture given to the Kansas City Area Diabetes Support Group. March 2005.

“Panhypopituitarism,” lecture given biannually at the Midwest regional Neonatal Nurses Update Course held at Children’s Mercy Hospital.

“Current Management of Diabetes in the Pediatric Setting,” lecture given at the Midwest regional Roche pharmaceutical representatives meeting. May 2006.

Editor of Fluids, Electrolytes, and Metabolism chapter in medical student review book.
June 2006

“Management of Thyroid Disease in Pediatrics,” lecture given to Springfield, MO area primary care physicians as part of subspecialty update. May 2007.

“Evaluation and Treatment of Type 1 Diabetes in Pediatrics,” lecture given to Springfield, MO area primary care physicians as part of subspecialty update. May 2007.

“Small for Gestational Age Infants and Growth,” lecture given to Failure to Thrive clinic at Children’s Mercy Hospital providers. July 2007

“Innovative Treatments in Type 2 Diabetes,” didactic lecture given to endocrine fellows and peers. August 2007.

“Exercise and Diabetes,” lecture given to Kansas and Missouri school nurses. September 2008.

“Interpretation of Continuous Glucose Monitoring,” lecture given at the Diabetes Education Center of the Midlands. Omaha, Nebraska. October 2008.

“Transition for Type 1 Diabetics.” Lecture given at the Great Plains Endocrine Symposium. Kansas City, MO. October 2011.

“Transition to Adult Care for Youth with Type 1 Diabetes.” Complex case panel discussion speaker at Heartland AACE Annual Meeting. August 25, 2012.

“LGBT Youth in the Primary Care Setting,” a panel discussion at 47th Annual Clinical Advances in Pediatrics Symposium. Kansas City, MO. September 17, 2014.

“Caring for Gender Non-Conforming Youth,” lecture at the Society of Pediatric Nurses Midwest Regional Conference. Kansas City, MO. September 23, 2017.

“EBM Based Care for Transgender Youth,” lecture for pediatric residents at CMH given annually as part of their evidenced based care lecture series. Spring 2017 to present.

“Trans Health Care Case Presentation and Discussion,” case presentations and round table discussion given at the Trans Health Inclusion Conference in Kansas City, MO. September 22, 2018.

“Transgender Pediatric Care 101,” webinar given for the members of the Society for Pediatric Nurses. February 25, 2019.

“Medication Management in Gender Transition,” lecture given at the 139th Kansas Pharmacists Association annual meeting. September 26th 2019.

EXHIBIT B

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