*** TO TYPE ON FORM OPEN IN PDF VIEWER (NOT IN BROWSER)

Save as Print Reset

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

DOMESTIC PARTNERSHIP COPY OF CERTIFICATE APPLICATION

Center for Policy Planning and Evaluation

Vital Records Division

TODAY'S DATE:

TYPE OF CERTIFICATE REQUESTED: **DOMESTIC PARTNERSHIP** ☐ **TERMINATION OF PARTNERSHIP** ☐

YEAR OF REGISTRATION:

REGISTRATION NUMBER:(if known)

PARTNER ONE'S NAME:

PARTNER TWO'S NAME:

CERTIFICATE FEE: $ 18 **x QUANTITY REQUESTED** **=** $ 0

TOTAL PAYMENT SUBMITTED = $ 0 *** QUANTITY MUST BE POPULATED TO CALCULATE TOTAL FEE

UPON APPROVAL THE PREFERRED PAYMENT METHOD IS: CREDIT/DEBIT CARD ☐ **CHECK/MONEY ORDER** ☐

APPLICANT NAME:

APPLICANT ADDRESS:

APPLICANT EMAIL: **APPLICANT PHONE:**

Signature: _____ Relationship: _____

REVISED: 03/23/2021