GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
AFFIDAVIT OF MUTUAL RESIDENCE
FOR DOMESTIC PARTNERSHIP REGISTRATION

Full Name of Registrant (I) (First-Middle-Last)	**Date of Birth**
Resident Address:	**SSN:**
Full Name of Registrant (II) (First-Middle-Last)	**Date of Birth**
Resident Address:	**SSN:**

I solemnly swear or affirm under penalty of perjury that I share a mutual residence with _____ named above as Registrant II.

_____ _____
Signature Registrant (I) **(Last) (First) (Middle)**

_____
Notary Public**

Sworn to and subscribed in my present on this (Month, Day, Year)_____

I solemnly swear or affirm under penalty of perjury that I share a mutual residence with _____ named above as Registrant I.

_____ _____
Signature Registrant (II) **(Last) (First) (Middle)**

_____
Notary Public**

Sworn to and subscribed in my present on this _____
(Month, Day, Year)