REQUEST FOR DECLARATION OF DOMESTIC PARTNERSHIP

		VITAL RECORDS USE ONLY
Full Name of Partner 1 (First, Middle, Last)	**Year of Registration**	
Full Name of Partner 2 (First, Middle, Last)	**Registration Number (if known)**	
Please check the appropriate box (es) and indicate the number of copies requested: **1. Registration including one certified certificate $45.00** **2. Certified certificate $18.00**	**Number of Copies ____**	
Signature of Applicant		**Date**

Name of Applicant _____

Address of Applicant _____

_____

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
VITAL RECORDS DIVISION

DOH-000 (Rev. 6/02)