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# BULLETIN NO. 116

**TO:** District of Columbia Agents

**FROM:** Alaine Belongia Donovan, District of Columbia Counsel

**DATE:** October 4, 2004

**SUBJECT:** Recordation & Transfer Tax Exemption for Domestic Partners

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Effective September 8, 2004, the Deed Recordation Tax and Related Amendments Amendment Act of 2004 (Bill 15-462) added an exemption for domestic partners from the DC transfer and recordation taxes. Parties seeking such exemption must register at the Department of Health. Find attached the **Affidavit of Mutual Residence For Domestic Partnership Registration** form and the **Domestic Partnership Registration** form, which must be completed by both persons, whose partnership is being requested. The following requirements must be met:

- Both applications must be 18 years of age
- Both applicants must be competent to contract
- Both applicants share a mutual residence
- Neither applicant is married or a member of another domestic partnership
- Both applicants are the sole domestic partner of the other
- Neither applicant has a pending termination of domestic partnership

The forms must be notarized and delivered to the Vital Records Division and provide proof of residency and identification. The Vital Records Division is

located within the Department of Health at 825 North Capitol Street NE, Washington, DC 20002.

Proof of mutual residence includes:

- Current residential lease or rental agreement naming both applicants as occupants;
- Current residential mortgage that names both applicants as mortgagors;
- Deed for residential property stating that both applicants share title to the premises;
- Current residential property utility bills naming both partners as responsible for payment; or
- An affidavit executed within the previous 6 months, in which both parties state, under penalty of perjury, that they both share the same residence

Also attached is the **Request for Declaration of Domestic Partnership** form. Fees for registration, inluding one certified certificate, are $45.00. A certified true copy of the certificate is $18.00. A record search (per name and year) is $10.

For additional questions, forms, fees and information regarding amendments, terminations, and withdrawal of domestic partnership terminations, please call the Vital Record Division at (202) 442-9303 or visit www.dchealth.dc.gov

**The Recorder of Deeds will require the attached Domestic Partnership Affidavit in order to substantiate the exemption, executed by both partners before a Notary Public.**

# DOMESTIC PARTNERSHIP AFFIDAVIT
## (Domestic Partners)

**Square**_____ **Suffix**_____**Lot**_____

**Print Name of Partner 1**_____ **Print Name of Partner 2**_____

**each being duly sworn on their oaths to severally depose and say that they are presently Domestic partners as certified by the Department of Health, District of Columbia. Affiants hereby affirm under penalty of law that the above statement and representation are correct and true to the best of their knowledge and belief. Furthermore, affiants hereby acknowledge that any false statement(s) or misrepresentation that they make on this form is punishable by criminal penalties under the law of the District of Columbia.**

_____
**Signature – Partner 1**

_____
**Signature – Partner 2**

**Subscribed and sworn to before me this**_____**day of** _____**, 200**____**.**

_____
**Notary Public**

**My Commission Expires:**_____
**mm/dd/yy**

# GOVERNMENT OF THE DISTRICT OF COLUMBIA
# DEPARTMENT OF HEALTH
# DOMESTIC PARTNERSHIP REGISTRATION FORM
## (D.C. Law 9-114)

File Number: _____ File Date: _____

We the undersigned, do declare that we meet the following requirements of 29 DCMR 8001.1:

- We are both at least 18 years of age.
- We are both competent to contract.
- We share a mutual residence.
- Neither of us is married or a member of another domestic partnership.
- Each of us is the sole domestic partner of the other.
- Neither of us has a pending termination of domestic partnership.

### Partner 1

| Name: First | Middle | Last | Date of Birth |
|---|---|---|---|
| Street: | | | |
| City: | State: | Zip: | |
| Social Security No.: | Home Phone: | Work Phone: | |

### Partner 2

| Name: First | Middle | Last | Date of Birth |
|---|---|---|---|
| Street: | | | |
| City: | State: | Zip: | |
| Social Security No.: | Home Phone: | Work Phone: | |

I acknowledge that the representations herein are true, correct and contain no material omissions of fact to the best of my knowledge and belief.

_____ _____
Signature Partner 1 Notary Public

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

I acknowledge that the representations herein are true, correct and contain no material omissions of fact to the best of my knowledge and belief.

_____ _____
Signature Partner 2 Notary Public

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

Please be advised that any material change to the information provided herein must be reported to the Vital Records Registrar.

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)

| 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:<br><br>1. Registration including one certified certificate $45.00<br>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)