This document prepared by
and return to:

DECLARATION OF DOMESTIC PARTNERSHIP

We swear or affirm under penalty of perjury that:

1. We are both at least eighteen (18) years old and competent to contract;

2. Neither of us is in a marriage recognized by the state of Florida nor a partner to another domestic partnership relationship;

3. Neither of us is related to the other by blood;

4. We are domiciled in Broward County, or are otherwise subject to the provisions of the Broward County Domestic Partnership Act of 1999;

5. We consent to this domestic partnership relationship and said consent has not been obtained by force, duress, or fraud;

6. We agree to be jointly responsible for each other's basic food and shelter during our domestic partnership;

7. Neither of us has had a different domestic partner within the last thirty (30) days.

8. Our names and mailing addresses are:

   Name____

   Address____

   City, State & Zip Code_________________________________

   Name____

   Address____

   City, State & Zip Code_________________________________

9. ☐ **By checking here I** request that this Declaration be considered a written inter vivos authorization and direction to have my domestic partner direct the disposition of my body for funeral, burial, or cremation purposes as a legally authorized person pursuant to Chapter 497, Florida Statutes. I understand that if I provide conflicting written inter vivos authorizations and directions that are dated after this Declaration, the later dated authorizations and directions shall control.

____
Name of Domestic Partner Date

10. ☐ **By checking here I** request that this Declaration be considered a written inter vivos authorization and direction to have my domestic partner direct the disposition of my body for funeral, burial, or cremation purposes as a legally authorized person pursuant to Chapter 497, Florida Statutes. I understand that if I provide conflicting written inter vivos authorizations and directions that are dated after this Declaration, the later dated authorizations and directions shall control.

____
Name of Domestic Partner Date

11. At least one of the following documents showing the same address for both Domestic Partners must be presented to the County. Copies may be presented in lieu of originals. Documentation will be returned to you. Please check those items presented.

☐ Current mortgage, deed, or lease

☐ Current driver's license or other government-issued photographic identification

☐ Most recent tax returns

☐ Current utility bill

☐ Current joint bank account

☐ Current designation as a health care surrogate

12. ☐ **By checking here I** authorize and consent to my domestic partner participating in the education of my dependent.

____
Name of Domestic Partner Date

☐ **By checking here I** authorize and consent to my domestic partner participating in the education of my dependent.

____
Name of Domestic Partner Date

13. ☐ **By checking here**, in the event I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate my domestic partner as my health care surrogate under section 765.202, Florida Statutes.

____

Name of Domestic Partner Date

____

Address of Domestic Partner Telephone Number

I fully understand that this designation will permit my domestic partner to make all health care decisions for me, which means my domestic partner has the authority to provide informed consent, refusal, or withdrawal of consent to any and all of my health care, including life prolonging procedures; apply on my behalf for private, public, government, or veterans' benefits to defray the cost of health care; access my health information reasonably necessary for my domestic partner to make decisions involving my health care to authorize my admission to or transfer from a health care facility.

While I have decision making capacity, my wishes are controlling, and my physicians and health care providers must clearly communicate to me the treatment plan or any change to the treatment plan prior to its implementation. To the extent I am capable of understanding, my domestic partner shall keep me reasonably informed of all decisions that my domestic partner has made on my behalf and matters concerning me.

THE DESIGNATION OF MY DOMESTIC PARTNER AS A HEALTH CARE SURROGATE IS NOT AFFECTED BY MY SUBSEQUENT INCAPACITY EXCEPT AS PROVIDED IN CHAPTER 765, FLORIDA STATUTES.

☐**By checking here**, in the event I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate my domestic partner as my health care surrogate under section 765.202, Florida Statutes.

____

Name of Domestic Partner Date

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Address of Domestic Partner Telephone Number

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THE DESIGNATION OF MY DOMESTIC PARTNER AS A HEALTH CARE SURROGATE IS NOT AFFECTED BY MY SUBSEQUENT INCAPACITY EXCEPT AS PROVIDED IN CHAPTER 765, FLORIDA STATUTES.

14. Last step:

(1) Sign this form in front of a Notary Public and have the Notary fill in the notarization at the bottom of this page; and

(2) Record this form with the Broward County Records, Taxes and Treasury Division, 115 South Andrews Avenue, Room 114, Fort Lauderdale, Florida.

To be able to record this form with the Broward County Records, Taxes and Treasury Division, you must be subject to the provisions of the Broward County Domestic Partnership Act OR both partners must be domiciled in Broward County.

☐ Check here to state that one of you is subject to the provisions of the Broward County Domestic Partnership Act.

☐ Check here to state that both partners are domiciled in Broward County.

I declare under penalty of perjury under the laws of the State of Florida that the statements contained in the Declaration of Domestic Partnership above are true and correct.

Signed on, ________________________, _____in ________________________________
(date signed) (place signed)

Signature _______________________________

Print Name ______________________________

Signed on, ________________________, _____in ________________________________
(date signed) (place signed)

Signature _______________________________

Print Name ______________________________

Acknowledgment:

State of _____________________

County of ____________________

The foregoing Declaration of Domestic Partnership was acknowledged before me, by means of ☐ physical presence or ☐ online notarization, this ____________ day of __________________, ______, by ____

and ____

☐ Personally Known OR ☐ Produced Identification

Type of Identification Produced ____

____
NOTARY PUBLIC

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