Vacation Rental Exemption Application

Application Overview and Instructions

A short-term rental shall operate as a vacation rental for no more than ninety (90) nights cumulatively in any calendar year, unless the host has received an exemption in accordance with Section 9904 of Title 14 of the District of Columbia Municipal Regulations (DCMR). A host may submit a vacation rental request for an exemption from the ninety (90) night limit under 14 DCMR § 9904.2 if:

- The host's employer, or the host's spouse or domestic partner's employer, requires the host, or the host's spouse or domestic partner, to work outside of the District for more than ninety (90) days cumulatively in any calendar year; or
- The host leaves the District to receive treatment for a serious health condition, or to care for a family member who is receiving treatment for a serious health condition, for more than ninety (90) days cumulatively in any calendar year.

Please send the fully completed Vacation Rental Exemption Application Form, the required notarized affidavit from the employer or medical provider, and, proof of travel, to shorttermrentals@dc.gov and the District of Columbia Short-Term Rental Program will review your request to determine whether you qualify for this exemption. All fields in the Vacant Rental Exemption Application Form must be completed as directed in order to qualify for this exemption.

Upon approval of this request, the host will be responsible for notifying the District of Columbia Short- Term Rental Program within ten (10) days of their return to the District.

District of Columbia Vacation Rental Exemption Form

Step 1. Select the applicable reason for your exemption under 14 DCMR § 9904.2

☐ Employment ☐ Medical

Step 2. Fill out all fields below:

1. Calendar Year Requesting Exemption: _____

2. Host Information
   a. Host name: _____
   b. Host's primary residence address:
      _____
   c. Host phone number: _____
   d. Host email address: _____
   e. Dates the host will reside outside of the District:
      _____
   f. Host address outside of the District during period of exemption:
      _____

3. Spouse/Domestic Partner Information Name (required if using to apply for exemption)
   a. Name of spouse/domestic partner: _____

4. Family Member Information (required if using to apply for exemption)
   a. Family member name: _____
   b. Host relationship to family member: _____

5. Employer/Employee Information (required if using to apply for exemption)
   a. Employee name: _____
   b. Employer name: _____
   c. Employer address: _____

d. Dates requiring host to reside outside of the District for employment:

_____

6. Medical Provider/Patient Information (required if using to apply for exemption)
    a. Patient name: _____
    b. Medical provider name: _____
    c. Medical provider address: _____
    d. Location of treatment outside of the District: _____
    e. Dates requiring host to reside outside of the District for the patient's medical treatment:

<u>Step 3</u>. Attach Proof of Travel (Proof of travel may include airline tickets, hotel reservations outside of the District, copy of lease outside of the District, or any other documentation that demonstrates the host will reside outside of the District.)

<u>Step 4</u>. Attach Notarized Affidavit of Employer (Part. A) or Notarized Affidavit of Health Care Provider (Part. B)

<u>Step 5</u>. Host Certification

I, _____ (Host Name) certify that I am the owner of _____ (Primary Residence Address); I attest that I will reside at _____ (Address Outside of the District) outside of the District from _____ (Date) to _____ (Date) for employment or medical treatment that qualifies me for a Vacation Rental Exemption pursuant to 14 DCMR § 9904.2.

Step 6. Explanation of Need for Travel:

I hereby certify all information submitted is true to the best of my knowledge.

Name of Host: _____

Signature of Host: _____

Date: _____

NOTARIZED AFFIDAVIT OF EMPLOYER

(Employer Only)

Part A. – Employer

I, _____ certify that I am _____ for
(Representative Name) (Position Title)

_____. I certify that _____ requested
(Employer) (Employer)

_____ to work at _____
(Employee) (Location Outside of the District)

from _____ to _____ and that I am authorized to provide this
(Date) (Date)

information on behalf of _____.
(Employer)

Employee Scope of Work:

I hereby certify all information submitted is true to the best of my knowledge.

Name of Representative (printed): _____
Position Title of Representative: _____
Email and Phone Number of Representative: _____
Email and Phone Number of Healthcare Provider: _____

_____
Signature of Representative

Subscribed and sworn before me, a Notary Public

SEAL

Notary _____
Today's Date _____
Commission Expires _____

AFFIDAVIT OF HEALTHCARE PROVIDER

(Healthcare Provider Only)

Part B. – Healthcare Provider

I, _____ certify that I am _____.
(Representative Name) (Position Title)

I certify that _____ is providing treatment for _____
(Healthcare Provider) (Patient)

at _____ from _____ to _____
(Location Outside of the District) (Date) (Date)

for a "serious health condition" as defined by D.C. Official Code § 32-541.01(20), and that I am authorized to provide this information on behalf of _____.
(Healthcare Provider)

I hereby certify all information submitted is true to the best of my knowledge.

Name of Representative (printed): _____
Position Title of Representative: _____
Email and Phone Number of Representative: _____
Email and Phone Number of Healthcare Provider: _____

_____
Signature of Representative

Subscribed and sworn before me, a Notary Public.

SEAL

Notary _____
Today's Date _____
Commission Expires _____