Washington State Bar Association
1325 Fourth Avenue, Suite 600
Seattle, WA 98101-2539

LIMITED PRACTICE BOARD

DECLARATION OF FINANCIAL RESPONSIBILITY COVERAGE

I, _____, understand my Limited Practice Certification is valid only while performing duties on behalf of and while covered under the errors and omissions insurance policy for my employer, _____

If I select, prepare or complete documents outside of this coverage, I will not be protected by this insurance coverage and will also be subject to revocation of my Limited Practice Officer certification.

I further agree to notify the Washington State Bar Association if my employment with the above-named employer is suspended or terminated. I further agree to advise the Washington State Bar Association if the above-specified insurance coverage is amended, suspended or terminated in any way which affects coverage for my activities as an LPO.

_____
Company (Employer)

_____
Address

_____
City/State/Zip Code

_____
Phone E-mail

_____
Signature Date signed