

The WSBA Administers the licensing and renewal process for Washington licensed legal professionals on behalf of and under rules adopted by the Washington Supreme Court and under the WSBA Bylaws.

I, _____, License No. _____, hereby request a stipulation to transfer my license status to Disability Inactive status due to a mental or physical incapacity to practice law. I acknowledge that the following apply to Disability Inactive status:

- When licensed legal professionals do not have the mental or physical capacity to practice law, they may stipulate to a transfer to Disability Inactive status.
- Licensed Legal Professionals with pending disciplinary investigations or proceedings may not use this form, and should contact the Office of Disciplinary Counsel (206-727-8207) about a transfer to Disability Inactive status.
- Licensed Legal Professionals who are requesting this status must submit medical and/or psychological documentation to support the request.
- Licensed Legal Professionals qualifying for transfer to Disability Inactive status may not practice law, and may participate in WSBA affairs only to the same extent as Inactive members.
- Licensed legal professionals on Disability Inactive status are not required to pay a license fee or any assessments, or earn or report MCLE credits while on Disability Inactive status, but they may choose to do so, and they may be required to earn and report MCLE credits in order to return to Active status.
- To return to Active status, the licensed legal professional has the burden of showing that the incapacity to practice law has been removed.

THE INFORMATION BELOW MUST BE PROVIDED.

PLEASE INCLUDE DETAILED INFORMATION THAT WILL FULLY CONVEY TO THE WSBA THE NATURE OF THE CIRCUMSTANCES PROMPTING THIS REQUEST. (Attach additional sheets as necessary; all sheets must be signed.)

State with particularity the nature of the incapacity to practice law. Include supportive facts and circumstances that form the basis upon which this request is made, and include your physician's or other treatment provider's record of diagnosis and the basis for incapacity to practice law. This documentation must also include the name and contact information of the attending/diagnosing physician(s); the date(s) of diagnosis; and summary of diagnosis.

I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct to the best of my knowledge.

Name (Please Print)

Date/Place Signed

Signature

Telephone Number

Mailing Address

Email Address (optional)

