WASHINGTON STATE
BAR ASSOCIATION
Regulatory Services Department

LPO DECLARATION OF FINANCIAL RESPONSIBILITY COVERAGE

I, _____, understand my Limited Practice Officer License 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 license.

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.

DATED this _____ day of _____ 20_____

*Signature:*_____

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