WSBA

REQUEST FOR STIPULATION TO INACTIVE-DISABILITY MEMBERSHIP UNDER RULE 8.5 OF THE RULES FOR ENFORCEMENT OF LAWYER CONDUCT (ELC)

I,_____, WSBA #_____, an Active member of the Washington State Bar Association, hereby request a stipulation to transfer my membership to Inactive-Disability membership due to a mental or physical incapacity to practice law. The following apply to Inactive-Disability:

- When a lawyer does not have the mental or physical capacity to practice law, he or she may stipulate to a transfer to Inactive-Disability membership.
- Members 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 Inactive-Disability membership.
- Members who are requesting this membership type must submit adequate medical and/or psychological documentation with the request.
- Members qualifying for transfer to Inactive-Disability membership may not practice law or participate in WSBA affairs.
- Inactive-Disability members are not required to pay a license fee or any assessments, or earn or report MCLE credits while on Inactive-Disability membership, but they may choose to do so, and they may be required to earn and report MCLE credits to return to Active membership.
- To return to Active membership, the member has the burden of showing that the disability has been removed.

THE INFORMATION BELOW MUST BE COMPLETED OR 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 member's incapacity to practice law. Include supportive facts and circumstances that form the basis upon which this request is made.

Please provide your physician's record of diagnosis and the basis for inability 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)