I, , have authorized the following attorneys to assist with the closure of my practice:

Name of Authorized Assisting Attorney: \_\_\_\_

Address:

Phone Number:

Name of Assisting Attorney’s Alternate: \_\_\_\_

Address:

Phone Number:

I, , have made arrangements with my financial institution to have an authorized signer on my Lawyer Trust Account:

Name of Authorized Signer on Lawyer Trust Account: \_\_\_\_

Address:

Phone Number:

*[Planning Attorney] [Date]*

*[Assisting Attorney] [Date]*

*[Alternate Assisting Attorney] [Date]*

*[Authorized Signer on Lawyer Trust Account] [Date]*

Mail this form to:

Director of Personal and Practice Management Assistance

Professional Liability Fund

PO Box 231600, Tigard, OR 97281-1600

**IMPORTANT NOTICES**

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