

LAWYER REFERRAL PROGRAM

Monmouth Bar Association
Court House, Freehold, NJ 07728
732-431-5544; Fax: 732-431-2843

NAME _____

OFFICE ADDRESS _____ PHONE _____

I AM (MEMBER OF THE FOLLOWING LAW FIRM): _____
(ASSOCIATED WITH): _____

DATE ADMITTED TO NEW JERSEY BAR _____
AND HAVE BEEN ENGAGED IN ACTIVE PRACTICE SINCE _____

PLEASE LIST LANGUAGES SPOKEN, AS WE ARE FREQUENTLY ASKED FOR LAWYERS FLUENT IN
LANGUAGES OTHER THAN ENGLISH _____

I AM LICENSED TO PRACTICE IN THE FOLLOWING STATES: _____

PLEASE INDICATE ONLY FOUR AREAS IN WHICH YOU ARE EXPERIENCED _____

I AM A CERTIFIED TRIAL ATTORNEY: CIVIL _____ CRIMINAL _____ MATRIMONIAL _____

MY PRACTICE INCLUDES FEDERAL WORKERS' COMPENSATION WORK _____

I HAVE INITIAL CONFERENCE FEE _____ DOLLAR AMOUNT _____ NONE _____

THIS DESIGNATION MUST BE MAINTAINED FOR ONE YEAR.

Membership in the Lawyer shall be conditional upon your meeting the following requirements:

- a. With the understanding that your compensation for any services will be arranged with the client.
- b. *That you warrant that you are a member in good standing of the Bar of the State of New Jersey and a member of the Monmouth Bar Association engaged in the active practice of law for a period of three years, that your name may be withdrawn from any or all classifications of the Program at the discretion of the majority of the members of the Monmouth Bar Association Referral Committee; and you also are permitted to withdraw your registration from any or all classifications of the Program at any time if you so notify the Committee.
- c. That you will abide by all rules of the Program which may be promulgated by the Committee; and that you carry Malpractice Insurance as listed below and will keep said insurance in full force and effect while a member of the Lawyer Referral Program.
- d. Your Monmouth Bar Association Dues must be current.
- e. Only members who practice the majority of their time within Monmouth County will be accepted as members of the Lawyer Referral Program. (**\$150 Annual Fee**)

I carry minimum malpractice insurance of \$500,000/1,000,000 with
_____ which is in full
force and effect from _____ to _____.

**Enclosed is proof of malpractice insurance. Enclosed is my
check/credit card information for \$150.00 the annual membership
fee for the Referral Program.**

Date _____ Signature _____

Cardholder Name _____
Street Address _____
City _____ State _____ Zip _____
Visa/MC/Amex # _____
Exp. Date ____/____ CVS# _____ (Visa/MC [3 digit] on back, Amex [4 digit] on front)
Signature X _____