



Office of the Secretary of State
Corporations & Charities Division

(360) 725 - 0378 | www.sos.wa.gov/charities

801 Capitol Way S, | PO Box 40234 | Olympia, WA 98504-0234

No fee

Expedite fee \$50

This Box For Office Use Only

CHARITABLE TRUST CLOSURE

RCW 11.110

All fields required unless otherwise specified

Registration # _____

(1) ORGANIZATION INFORMATION:

Organization Name:

If organization's mailing address is no longer valid please provide an address where the closure document(s) can be mailed.

Attention to: _____

Address _____

City _____ State ____ Zip _____

Date of Closure: _____ mm/dd/yyyy

(2) ORGANIZATION'S FINANCIAL INFORMATION

Please check the type of tax return that was filed for the final accounting year: The form **MUST** be enclosed .

(Check one) 990 990EZ 990PF 990N Other and continue to fill out the financial information below.

FINANCIAL REPORT FOR PRECEDING, COMPLETED ACCOUNTING YEAR

ALL below financial fields must be completed. Enter zero if the organization does not have any financial

Organization's Accounting Year Begin Date

Organization's Accounting Year End Date

_____ (mm/dd/yyyy)

_____ (mm/dd/yyyy)

1. Beginning Gross Assets: \$ _____

2. Total Revenue: \$ _____

3. Grants, Contributions and Program Services: \$ _____

4. Compensation officer/directors/trustees: \$ _____

5. Total Expenses: \$ _____

6. Ending Gross Assets: \$ _____

Registration # _____

(3) ORGANIZATION'S FINANCIAL PREPARER:

PERSON OR BUSINESS THAT PREPARES, REVIEWS, OR AUDITS FINANCIAL INFORMATION, IF ANY, OR PERSON OR ENTITY THAT COMPLETED THE FINANCIAL REPORT

If the Financial Report on page 3 has been completed, the below information **must** be provided.

Please check one and fill out the corresponding section below.

Entity - Entity's Name: _____

Representative's Name: _____ Title: _____

Address _____ City _____ State _____ Zip _____

Individual - Name: _____ Title: _____

Address _____ City _____ State _____ Zip _____

(4) CLOSURE REASON

Closure Reasons: Organization no longer exists Organization is not required to register
 Organization is domiciling in another state Other (fill out below):

(5) ORGANIZATION'S DISSOLUTION ATTESTATION

By checking the box you confirm the below statement.

The Trust is dissolved and all assets have been distributed per the trust instrument.

(6) RETURN ADDRESS FOR THIS FILING: (optional)

Documents pertaining to this specific filing will be sent to the address below, if provided, in addition to the Organization's mailing address.

Attention to: _____

Email: _____

Address: _____

City _____ **State** _____ **Zip** _____

(7) SIGNATURE (Required)

By executing this document, the applicant certifies the following:

- He/she is authorized to represent the above-named charitable trust.
- The information contained herein is accurate and true to the best of the applicant's knowledge.

X _____

Signature of Applicant

Printed Name / Title

Date

Contact phone number _____