American Midwifery Certification Board, Inc. (AMCB)
849 International Dr. Suite 120
Linthicum, MD 21090
(410) 694-9424; (410) 694-9425 FAX

Consent to Serve
COMMITTEE MEMBERS

NAME:________________________________ DATE: ______

COMMITTEE (Check one):
_____ Certification Maintenance Program (CMP) Committee
_____ Credentials, Administration & Reporting (CAR) Committee
_____ Examination Committee
_____ Finance Committee
_____ Research Committee

TERM: 3 years beginning January 1 of the year of appointment

I will diligently and faithfully perform the duties of committee membership as defined by the committee chairperson. I will treat confidential information obtained in the course of my AMCB functions properly. I recognize that in this office I must seek to advance the mission and interests of AMCB and act on AMCB's behalf only to the extent expressly provided in its bylaws and designated by its policies. I am not authorized to and I shall not represent myself as authorized to, act contrary to nor in excess of the authority so granted to me.

____
Signature Date

____
Please type or print name Credential(s) in preferred order

____
Practice Setting

Preferred Mailing Address: Home_____________ Office____________

____
Street

____
City/State/Province/Zip Code

Email: __________________________@___________________

Telephone(s):

Home: ( ) __________________________ Mobile: ( ) _________________________

Office: ( ) __________________________ Fax: ( ) ____________________________