

**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):

- \_\_\_\_\_ External Review Sub-Committee
- \_\_\_\_\_ External Item Writing Sub-Committee
- \_\_\_\_\_ Pass Point Sub-Committee

TERM: 2 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: (    ) \_\_\_\_\_