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: 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: ( ) _____