

**American Midwifery Certification Board, Inc. (AMCB)**

849 International Dr. Suite 120  
Linthicum, MD 21090  
(410) 694-9424; (410) 694-9425 FAX

Consent to Serve

**BOARD OF DIRECTORS & COMMITTEE CHAIRPERSONS**

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

BOARD OF DIRECTORS (check one category and appropriate subcategory):

\_\_\_\_\_ Officer

\_\_\_\_\_ President

\_\_\_\_\_ Treasurer

\_\_\_\_\_ Secretary

\_\_\_\_\_ Committee Chairperson

\_\_\_\_\_ CAR Committee chair

\_\_\_\_\_ CMP Committee chair

\_\_\_\_\_ Examination Committee chair

\_\_\_\_\_ Research Committee chair

\_\_\_\_\_ Director

\_\_\_\_\_ Professional liaison

\_\_\_\_\_ Consumer member

TERM: 3 years beginning January 1 of the year of appointment; renewable for a second term; total term not to exceed 6 years.

I will diligently and faithfully perform the duties of the office on the AMCB Board of Directors as defined by corporation's bylaws. 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.

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Signature

Date

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Please type or print name

Credential(s) in preferred order

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Practice Setting

Preferred Mailing Address: Home \_\_\_\_\_ Office \_\_\_\_\_

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Street

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City/State/Province/Zip Code

Email: \_\_\_\_\_@\_\_\_\_\_

Telephone(s):

Home: (     ) \_\_\_\_\_ Mobile: (     ) \_\_\_\_\_

Office: (     ) \_\_\_\_\_ Fax: (     ) \_\_\_\_\_