

American Midwifery Certification Board, Inc. (AMCB)

849 International Dr. Suite 205
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

_____-_____-_____
Social Security Number

Practice Setting

Preferred Mailing Address: Home _____ Office _____

Street

City/State/Province/Zip Code

Telephone(s):

Home: () _____ Office: () _____

Fax: () _____ Email: _____@_____