

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

8825 Stanford Blvd., Suite 150  
Columbia, MD 21045  
410-694-9424; 410-290-0121 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: (    ) \_\_\_\_\_