

**Arkansas Alternative Dispute Resolution Commission**

625 Marshall Street, Little Rock, Arkansas 72201

**APPOINTMENT OF AGENT TO RECEIVE SERVICE OF PROCESS**

**Please Type or Print**

Name of Mediator: \_\_\_\_\_

Federal Tax ID (if any): \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

**Name and street address of person authorized as agent to receive service of process:**

Name of Agent: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

I, \_\_\_\_\_, do hereby appoint the above-stated person as agent to receive service of process.

**By signing this document, I agree to submit to the jurisdiction of Arkansas courts.**

Mediator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I, \_\_\_\_\_, do hereby accept this appointment as AGENT to receive service of process.

Agent Signature: \_\_\_\_\_ Date: \_\_\_\_\_