

REGISTRATION:

NEW YORK SOCIETY OF CLINICAL HYPNOSIS

BASIC HYPNOSIS WORKSHOP

For Health Care Professionals

March 10<sup>th</sup> and 11<sup>th</sup>, 2012

NAME \_\_\_\_\_

DEGREE \_\_\_\_\_ Year Granted \_\_\_\_\_ Today's Date \_\_\_\_\_

FEE ENCLOSED:

Member: NYSCH, ASCH or SCEH \$ \_\_\_\_\_

Non-member: \$ \_\_\_\_\_

Full-Term Faculty, Resident,

Intern or Graduate Student\* \$ \_\_\_\_\_

\*With this registration form and check or money order, send a letter signed by your department chair certifying your status.

University/Hosp/Affiliation Name: \_\_\_\_\_

Licensed in: Specialization \_\_\_\_\_ State \_\_\_\_\_

License# \_\_\_\_\_

MAIL AND PHONE INFORMATION

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

ADDRESS: \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

PHONE [ HOME] \_\_\_\_\_ [WORK] \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

Note: During the course you may be asked to undergo trance experience. If there is any reason why you should not do so, sign below. Please understand that declining trance experiences will limit your participation in small group sessions.

I CHOOSE NOT TO UNDERGO TRANCE EXPERIENCES

Signature: \_\_\_\_\_

MAKE U.S. CHECK OR MONEY ORDER PAYABLE TO NYSCH

MAIL TO:

NYSCH

c/o Ita O'Sullivan, Treasurer  
25 Central Park West, Suite 1L  
New York, NY 10023