

New York Society of Clinical Hypnosis — Registration Form

BASIC CLINICAL HYPNOSIS WORKSHOP For Health Care Professions

April 5th, 6th, & 12th 2014

Name: _____

Degree: _____ Year Granted: _____ Today's Date: _____

FEE ENCLOSED: \$ _____

*** Full Tuition Refund up until March 22, 2014**

	Attending All 3 Days [20 credits]	Apr 5th&6th ONLY [12 credits]
Member (NYSCH, ASCH, or SCEH):	\$425	\$250
Non-member:	\$475	\$300
Full-Term Faculty, Resident, Intern, or *Graduate Student:	\$300	\$175

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

University/Hospital/Affiliation Name: _____

Licensed In: Specialization: _____ State: _____ License#: _____

CONTACT INFORMATION:

Address: _____

City, State/Province: _____ Country: _____ ZIP: _____

Email address: _____

Telephone _____

Home/Office: _____ Fax: _____ Cell: _____

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, 14 Rye Ridge Plaza Suite 223, Rye Brook, NY 10573**