NY Society of Clinical Hypnosis - Registration Form

BASIC CLINICAL HYPNOSIS WORKSHOP
For Health Care Professions

Saturday, April 18th & Sunday, April 19th, 2015   8AM-6PM

Name: ______________________________

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

FEE ENCLOSED: **$** ____________ *** NO REFUNDS after April 1st, see below**

WORKSHOP FEES	**BEFORE March 15th:**	**AFTER March 15th:**
Member (NYSCH, ASCH, SCEH):	$425	$475
Non-member:	$475	$525
Full-Term Faculty, Resident, Intern, or *Graduate Student:	$300	$350

*** 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#: ______________

CANCELLATION POLICY: Cancellations postmarked on or before April 1st, 2015 will receive a refund of the amount paid less a $50 administrative charge. NO REFUNDS after APRIL 1st, 2015.

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**