NY Society of Clinical Hypnosis - Registration Form

INTERMEDIATE CLINICAL HYPNOSIS WORKSHOP
For Health Care Professions

Saturday, September 6th, 2014	9AM-5PM [Lectures]
Saturday, September 13th, 2014	9AM-5PM [Lectures]
Sunday, September 14th, 2014	1PM-5PM [Practicum]

Name: _____

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

*** Prerequisite for this Intermediate Workshop is the Basic Workshop. Date/Place taken:** _____

FEE ENCLOSED: **$** _____ *** Full Tuition Refund up until August 23, 2014**

Member (NYSCH, ASCH, or SCEH):	$450
Non-member:	$500
Full-Term Faculty, Resident, Intern, or *Graduate Student:	$285

*** 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**