

# The New York Society of Clinical Hypnosis, Inc.

---

Founded 1974 ☉ A Component Section of the American Society of Clinical Hypnosis, Inc.

## **BOARD OF DIRECTORS AND OFFICERS**

### PRESIDENT

Marlene Levy, PhD, DAAPM

### RECORDING SECRETARY

Diane Haber, MS, RN, CS

### VICE PRESIDENT

Herbert Feldman, MD, DABFM, DAAPM

### REPRESENTATIVE TO ASCH

Phyllis Gildston, PhD

### TREASURER

Ita O'Sullivan, RN, NP

### MEMBER-AT-LARGE

Richard Tuck, PsyD

Susan Lee Bady, LCSW, BCD

## **RE: 2016-17 NYSCH MEMBERSHIP**

Dear Colleague,

It's that time again, to renew your NYSCH (The New York Society of Clinical Hypnosis) membership . Our membership organization is committed to advancing knowledge and training in the Art and Science of Clinical Hypnosis. Membership is open to all LICENSED HEALTH CARE PROFESSIONALS holding a master's degree and/or above; student memberships are offered for those enrolled in full-time Master's Level or above degree programs.

Our meetings historically have been held in Queens or Long Island, in order to be more available to all practitioners in the five boroughs, Long Island, Westchester, New Jersey, and Connecticut.

## **BENEFITS OF MEMBERSHIP:**

- Free admission to our [4] yearly training courses
- 8 credits toward your ASCH certification\*
- Networking
- Referrals
- Collegial atmosphere

**\*All training courses and workshops are taught by a member of Board of Directors (all of whom are licensed ASCH Consultants) and/or other skilled, licensed clinicians, and will have received approval for ASCH credit.**

**\*Spring BASIC and Fall INTERMEDIATE Workshops provide 40 credits [20 credits each workshop] toward your ASCH certification.**

# NY Society of Clinical Hypnosis - Membership Form 2016-17

1. Full Name: \_\_\_\_\_  
Last First Middle

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

City, State/Province: \_\_\_\_\_ Country: \_\_\_\_\_ ZIP: \_\_\_\_\_

Email address: \_\_\_\_\_

Telephone

Home/Office: \_\_\_\_\_ Fax: \_\_\_\_\_ Cell: \_\_\_\_\_

2. Which membership category are you applying for?  Full  Student

3. Education  
Institution: \_\_\_\_\_ Degree: \_\_\_\_\_ Date: \_\_\_\_\_

Institution: \_\_\_\_\_ Degree: \_\_\_\_\_ Date: \_\_\_\_\_

Institution: \_\_\_\_\_ Degree: \_\_\_\_\_ Date: \_\_\_\_\_

Institution: \_\_\_\_\_ Degree: \_\_\_\_\_ Date: \_\_\_\_\_

**If applying for Student membership, a letter from your advisor/department head/Registrar certifying your current level of education must accompany you completed application.**

4. Licensed to Practice as:

Physician  Psychologist  Dentist  Social Worker

Nurse  Mental Health Counselor  Chiropractor  Marriage/Family Therapist

Speech-Language Pathologist  Other: \_\_\_\_\_

If other, please explain: \_\_\_\_\_

State/Province in which licensed: \_\_\_\_\_ License #: \_\_\_\_\_

**A copy of your current license to practice, with expiration date, must accompany your completed application.**

Attach check for annual dues which are as follows: **Full Member \$ 70** \_\_\_\_\_ **Student Member: \$40** \_\_\_\_\_

Mail completed application form and appropriate check to:

NYSCH  
c/o **Ita O'Sullivan**  
14 Rye Ridge Plaza, Suite 223  
Rye Brook, NY 10573

The facts set forth in my application are true and complete. I understand that false statements on this application shall be considered sufficient cause for rescinding membership. **YOU MUST SIGN YOUR APPLICATION:**

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