

# NY Society of Clinical Hypnosis - Registration Form

## **BASIC CLINICAL HYPNOSIS WORKSHOP For Health Care Professions**

Saturday, November 18<sup>th</sup> & Sunday, November 19<sup>th</sup>, 2017 8AM-6PM

Name: \_\_\_\_\_

Degree: \_\_\_\_\_ Year Granted: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**FEE ENCLOSED:**                    \$ \_\_\_\_\_

**\* NO REFUNDS after November 3<sup>rd</sup>, see below**

<b>WORKSHOP FEES</b>	<b>BEFORE Oct 20<sup>th</sup>:</b>	<b>AFTER Oct 20<sup>th</sup>:</b>
Member (NYSCH, ASCH, SCEH):	\$425	\$500
Non-member:	\$475	\$550
Full-Term Faculty, Resident, Intern, or *Graduate Student:	\$325	\$400

**\* 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 November 3, 2017 will receive a refund of the amount paid less a \$50 administrative charge. **NO REFUNDS after November 3, 2017.**

### **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, 110 West 9th Street, Suite 1D, New York NY 10025**