

# NY Society of Clinical Hypnosis - Registration Form

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

Friday, April 15<sup>th</sup> & Saturday, April 16<sup>th</sup>, 2016 8AM-6PM

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

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

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

\* NO REFUNDS after April 1st, see below

<b>WORKSHOP FEES</b>	<b>BEFORE March 15th:</b>	<b>AFTER March 15th:</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 April 1st, 2016 will receive a refund of the amount paid less a \$50 administrative charge. NO REFUNDS after APRIL 1st, 2016.

### **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**