NY Society of Clinical Hypnosis - Registration Form

BASIC CLINICAL HYPNOSIS WORKSHOP
For Health Care Professions

Saturday, April 1st & Sunday, April 2nd, 2017 8AM-6PM

Name: _____

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

FEE ENCLOSED: **$** _____ *** NO REFUNDS after March 15th, see below**

WORKSHOP FEES	BEFORE March 11th:	AFTER March 11th:
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 March 15th, 2017 will receive a refund of the amount paid less a $50 administrative charge. NO REFUNDS after MARCH 15th, 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, 14 Rye Ridge Plaza Suite 223, Rye Brook, NY 10573**