

# NY Society of Clinical Hypnosis - Registration Form

## INTERMEDIATE CLINICAL HYPNOSIS WORKSHOP For Health Care Professions

November 2<sup>nd</sup> & 3<sup>rd</sup>, 2013

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 October 19, 2013

Member (NYSCH, ASCH, or SCEH): \$425

Non-member: \$475

Full-Term Faculty, Resident, Intern, or \*Graduate Student: \$260

\* 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**