

APPLICATION FOR MEMBERSHIP

(Please type or print legibly. See membership requirements.)

Name in Full _____ Degree _____

Office Address _____ Telephone _____

City, State, Zip _____

E-mail Address _____

Home Address _____ Telephone _____

City, State, Zip _____

EDUCATION:

Undergraduate/University _____ Degree _____ Date _____

Graduate/University _____ Degree _____ Date _____

Postgraduate _____ Degree _____ Date _____

Major Field of Study _____

Student (full-time) (where) _____

Degree to be earned _____ Expected Date of Completion _____

Letter from department head certifying current enrollment must accompany completed application.

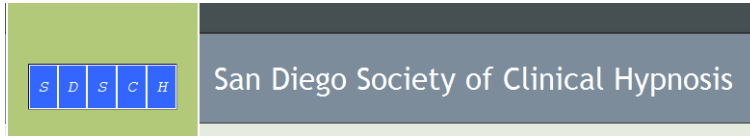
TYPE OF PRACTICE

Check appropriately: Full-Time Practice Part-Time Practice Resident/Intern

TYPE OF LICENSE _____ **License/Registration No.** _____

TEACHING POSITIONS

(where) _____



LIST MEMBERSHIP IN PROFESSIONAL ORGANIZATION

ASCH: _____ YES _____ NO

OTHER _____

Specialty Board Certification _____

Verify your training in hypnosis within the last three years. Please indicate what courses you have taken in hypnosis, where they were held, including dates and number of hours. Please furnish proof of attendance.

List use of and expertise in hypnosis: _____

What would you like to get from being a member of SDSCH virtual society? _____

With which of the following might you be willing to assist?

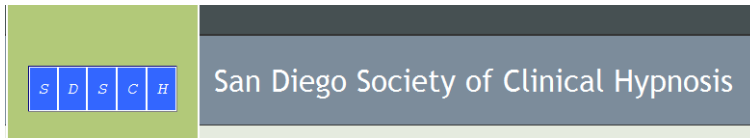
___ Membership acquisition and retention

___ Organizing workshops and continuing education

___ Public relations

___ Website maintenance

Please note topics relative to hypnosis in which are you interested in learning more:



Please list any colleagues or friends who you would like us to contact about membership interest in SDSCH or SDSCH listing:

Name: _____ Phone _____ E-mail. _____

Name: _____ Phone _____ E-mail. _____

Name: _____ Phone _____ E-mail. _____

Attach copy of your license, your CV, and enclose a check of annual listing fee payable to SDSCH. Mail with completed application to

Suzanne Marcus:
3252 Holiday Ct, # 225,
La Jolla, CA 90237
Email: contactsdsch@sdsch.com
858 622 9006

You will be notified by email regarding your website listing status. If application is not accepted, money will be refunded.

1. Register Listing as: _____ Full Member \$90 _____ Associate Member \$60
_____ Resident /Intern Affiliate \$25 _____ Student Affiliate \$25
2. Detailed Listing with photo: _____ \$120
3. Advertisement of Workshop (for members only): _____ \$100 per 3 months

I hereby apply for website membership listing in the San Diego Society of Clinical Hypnosis, and, if accepted, I agree to abide by Bylaws of the Society and the ASCH Code of Ethics and to practice in accordance with established ethical usages of my profession.

Signature of Applicant _____

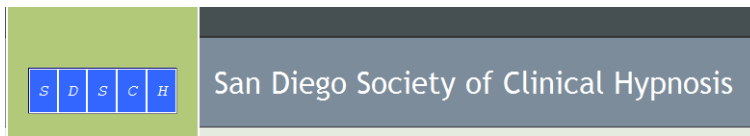
Date _____

DO NOT WRITE BELOW THIS LINE—FOR BOARD USE ONLY

Recommendation of Committee: ___ Full ___ Associate ___ Affiliate ___ Student ___ N/A

Date _____ Signature _____

(SDSCH App. Form 2009)



Website Referral and Listing Information

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: (____) _____ - _____ Ext: _____
 Email: _____
 (please print carefully)
 Site: www. _____ . _____

Office Information:
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: (____) _____ - _____ Ext: _____

Ages served:	<input type="checkbox"/> preschool	Therapy with:	<input type="checkbox"/> individual
	<input type="checkbox"/> children		<input type="checkbox"/> couples
	<input type="checkbox"/> teenagers		<input type="checkbox"/> families
	<input type="checkbox"/> adults		<input type="checkbox"/> groups
	<input type="checkbox"/> geriatric		<input type="checkbox"/> business settings

Specialties:

<input type="checkbox"/> addiction	<input type="checkbox"/> irritable bowel syndrome	<input type="checkbox"/> stress
<input type="checkbox"/> anxiety	<input type="checkbox"/> mood disorders	<input type="checkbox"/> surgery
<input type="checkbox"/> asthma	<input type="checkbox"/> pain	<input type="checkbox"/> stuttering
<input type="checkbox"/> coping with infertility	<input type="checkbox"/> past life therapy	<input type="checkbox"/> TMJ
<input type="checkbox"/> dental	<input type="checkbox"/> phobias	<input type="checkbox"/> trauma/PTSD
<input type="checkbox"/> depression	<input type="checkbox"/> preparing for childbirth	<input type="checkbox"/> trichotillomania
<input type="checkbox"/> headaches	<input type="checkbox"/> performance anxiety	<input type="checkbox"/> tics disorder
<input type="checkbox"/> insomnia	<input type="checkbox"/> smoking cessation	<input type="checkbox"/> weight loss

What other categories would you like to see listed:
 _____ _____ _____

License # and Licensing Board: _____
 Malpractice insurance \$ _____ / \$ _____ (this info will not be posted)
 List memberships & status you would like included: (e.g., ASCH, Approved Consultant):

Languages Spoken: _____
 Insurance Accepted: _____

I attest that the above information is true and accurate.

Signed _____ Date _____