



**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: \_\_\_\_\_

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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

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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"/> tricholtillomanin
<input type="checkbox"/> headaches	<input type="checkbox"/> performance anxiety	<input type="checkbox"/> tourettes 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



## San Diego Society of Clinical Hypnosis

### 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.*

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

Teaching Positions (where) \_\_\_\_\_

Type of License \_\_\_\_\_ License/Registration No. \_\_\_\_\_



## San Diego Society of Clinical Hypnosis

List membership in professional organization: \_\_\_\_ YES \_\_\_\_ NO \_\_\_\_\_

ASCH: \_\_\_\_\_

\_\_\_\_\_

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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



# San Diego Society of Clinical Hypnosis

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 92037*

Email ContactSDSCH@sdsch.com  
858 622 9006

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

- 1. Register Listing as:  Introductory New Member Rate \$60
- Regular Rate Full Member \$90

**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 \_\_\_\_\_