



Full or Associate Membership

Personal Information

Name: _____
First Middle Last Credentials

Company: _____ Job Title: _____

Address: _____
Street

City State Postal Code Country

Phone: _____ Fax: _____

E-mail: _____ Date of Birth: _____

Website: _____

Education

Your most advanced degree (from an accredited university) and field in which it was granted:

Degree Field

College or University: _____

City & State: _____ Year of Graduation: _____

Licensure

A copy of your current license or certification to practice, with expiration date, must accompany your completed application.

Field: _____ License #: _____

State or Province of Licensure: _____ Date of Expiration: _____

Country (if outside of the United States): _____

Professional Memberships

Proof of current membership, or eligibility for membership, in a professional organization relevant to your degree (ex: NASW, APA, AMA, AAMFT, ADA, etc.) must accompany your completed application.*

Professional Organization(s): _____

**If you are not a current member of a professional organization relevant to your degree, please include a statement with you application that you are eligible to join, but choose not to.*

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Referral

Were you referred by a current ASCH member? Yes No

If yes, please tell us who referred you: _____

If no, how did you hear about ASCH: _____

Additional Material

- Certificates of completion for any hypnosis training you have taken (one 20 hour ASCH-approved course required for Full membership).
- Include a short statement on your interest in hypnosis.

Please check the following boxes as appropriate and complete the signature line below (this must be done in order for you application to be processed):

I agree to accept the ASCH Code of Conduct (which can be found on www.asch.net for review).

The foregoing information has been voluntarily supplied by the undersigned, with the understanding that it will be reviewed by the Membership Committee of ASCH and that, in the process of verification of the facts stated in the application, such facts may become known to third parties, and the undersigned expressly waives any claim to confidentiality of the material stated herein. I understand that false statements on this application shall be considered sufficient cause for rescinding membership.

I hereby agree that I am submitting this application voluntarily and that, if my application is not acted upon favorably, I will in no way seek to hold ASCH, or any of its officers, members, or agents responsible for action.

By submitting this application I agree that I understand that the rules and statutes of the states vary in terms of the use of clinical hypnosis and that individuals accept responsibility for the care of their clients or patients consistent with the individuals' discipline and licensure and that they should seek out consultation and/or supervision when in doubt regarding their clinical practices or when questioned by others about their clinical practice and that I will only use hypnosis within the scope of my practice.

Signature

Date

Payment

\$235 U.S.

\$210 Canada

Credit Card

Check one: Visa Mastercard

Credit Card #: _____

Expiration Date: _____ Security Code: _____

Name on Card: _____

Cardholder's Signature: _____ Date: _____

Check

Please make checks payable to:
"American Society of Clinical Hypnosis"

Check Number _____