American Society of Clinical Hypnosis Membership Application

Resident/Intern 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

Resident/Intern Members should be full-time residents or interns participating in a recognized residency or internship program which will qualify them for licensed practice in a health care discipline considered appropriate by the Society.

Resident/Intern Membership is also available for those that have completed a graduate degree in a medical or mental health care field and are currently practicing under a licensed professional for hours towards licensure.

An applicant for Resident/Intern Membership must provide a statement from their supervisor that indicates their expected completion date of the residency or internship.

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: ______________

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?: ____

Resident/Intern Membership

Additional Material

Certificates of completion for any hypnosis training you have taken (one 20 hour ASCH-approved course required for Full membership).

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

❑ $115 U.S. ❑ $102.50 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 ____________

140 N. Bloomingdale Rd., Bloomingdale, IL 60108 · (p) 1.630.980.4740 · (f) 1.630.351.8490 · membership@asch.net · www.asch.net