



# Student Affiliate 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

Student Affiliate Membership is available for full time students who have successfully completed a minimum of one graduate semester or quarter in a graduate program which will qualify them for licensed practice in a medical or mental health care discipline.

A Student Affiliate shall be pursuing his/her doctoral or master’s degree at a university or college fully accredited by its appropriate regional accrediting body to give such a degree.

Student Affiliate status shall be granted for a maximum of two years at a time for doctoral students and one year for master’s students.

**Applicants for Student Affiliate Membership must provide a letter from their advisor/department head/registrar certifying that they have completed at least one graduate term and are currently enrolled full time in a graduate degree program (the degree program must be specified).**

Degree in progress (from an accredited university) and field of study:

\_\_\_\_\_ Degree \_\_\_\_\_ Field

College or University: \_\_\_\_\_

City & State: \_\_\_\_\_

Expected Date of Completion: \_\_\_\_\_

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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).

**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](http://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

\$95 U.S.

\$82.50 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 \_\_\_\_\_