

**APPLICATION FOR PARTICIPATION IN  
AMERICAN SOCIETY OF CLINICAL HYPNOSIS (ASCH)  
INDIVIDUAL CONSULTATION (IC) /  
INDIVIDUAL CONSULTATION WORKSHOP (ICW)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Telephone: \_\_\_\_\_

Degree \_\_\_\_\_ Specialty: \_\_\_\_\_

State/Province of Licensure: \_\_\_\_\_ License No.: \_\_\_\_\_

Expiration of Current Licensure: \_\_\_\_\_

Please list professional organizations of which you are currently a member or are eligible for membership: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**IC / ICW Application, page two**

Are you a member of ASCH: No \_\_\_\_\_ Yes \_\_\_\_\_ Year of initial membership \_\_\_\_\_

Dates and Location of completion of ASCH-ERF-sponsored / ASCH-approved **Level 1 (Fundamentals / Basic)** Workshop: **[If not ASCH-ERF sponsored but ASCH-approved, please also list sponsor/provider of Level 1 workshop training]**

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Dates and Location of completion of ASCH-ERF-sponsored / ASCH-approved **Level 2 (Intermediate)** Workshop: **[If not ASCH-ERF sponsored but ASCH-approved, please also list sponsor/provider of Level 1 workshop training]**

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Dates and Locations of completion of ASCH-ERF / ASCH-approved **Advanced Workshop(s)**:

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Are you applying for enrollment in: Individual Consultation (**IC**) \_\_\_\_\_  
Individual Consultation Workshop (**ICW**) \_\_\_\_\_

When would you like to begin / when do you anticipate beginning the IC / ICW program:

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If applying for **IC**, have you established an agreement with an ASCH Approved Consultant(s) who will provide consultation services for you on an individual basis: No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, with whom: \_\_\_\_\_

If applying for **ICW**, when would you like to attend the 20-hour extended weekend workshop:

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