

# The New York Society of Clinical Hypnosis, Inc.

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Founded 1974 ☉ A Component Section of the American Society of Clinical Hypnosis, Inc.

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## **RE: ANNUAL NYSCH MEMBERSHIP**

Dear Colleague,

It's that time again, to renew your NYSCH (The New York Society of Clinical Hypnosis) membership . Our membership organization is committed to advancing knowledge and training in the Art and Science of Clinical Hypnosis. Membership is open to all LICENSED HEALTH CARE PROFESSIONALS holding a master's degree and/or above; student memberships are offered for those enrolled in full-time Master's Level or above degree programs.

Our meetings historically have been held in Queens or Long Island, in order to be more available to all practitioners in the five boroughs, Long Island, Westchester, New Jersey, and Connecticut.

## **BENEFITS OF MEMBERSHIP:**

- Free admission to our [4] yearly training courses
- 8 credits toward your ASCH certification\*
- Networking
- Referrals
- Collegial atmosphere

➤ **All training courses and workshops are taught by a member of the Board of Directors (all of whom are licensed ASCH Consultants) and/or other skilled, licensed clinicians, and will have received approval for ASCH credit.**

➤ **Spring BASIC and Fall INTERMEDIATE Workshops provide 40 credits [20 credits each workshop] toward your ASCH certification.**

# NY Society of Clinical Hypnosis - Annual Membership Form

1. Full Name: \_\_\_\_\_  
Last First Middle

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

City, State/Province: \_\_\_\_\_ Country: \_\_\_\_\_ ZIP: \_\_\_\_\_

Email address: \_\_\_\_\_

Telephone

Home/Office: \_\_\_\_\_ Fax: \_\_\_\_\_ Cell: \_\_\_\_\_

2. Which membership category are you applying for?  Full  Student

3. Education  
Institution: \_\_\_\_\_ Degree: \_\_\_\_\_ Date: \_\_\_\_\_

Institution: \_\_\_\_\_ Degree: \_\_\_\_\_ Date: \_\_\_\_\_

Institution: \_\_\_\_\_ Degree: \_\_\_\_\_ Date: \_\_\_\_\_

Institution: \_\_\_\_\_ Degree: \_\_\_\_\_ Date: \_\_\_\_\_

**If applying for Student membership, a letter from your advisor/department head/registrar certifying your current level of education must accompany your completed application.**

4. Licensed to Practice as:

- Physician  Psychologist  Mental Health Counselor  Social Worker  
 Nurse  Dentist  Speech-Language Pathologist  Marriage/Family Therapist  
 Chiropractor  Other: \_\_\_\_\_

If other, please explain: \_\_\_\_\_

State/Province in which licensed: \_\_\_\_\_ License #: \_\_\_\_\_

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

Attach check for annual dues which are as follows: **Full Member: \$75** \_\_\_\_\_ **Student Member: \$45** \_\_\_\_\_

Send check, money order, or use ZELLE [treasurer@nysch.org] to pay your dues, and send your completed application to our Treasurer at the address below:

**NYSCH**  
c/o Victor Kiarsis, LMSW, MBA  
14 Elm Street, Suite 204  
Rye, NY 10580

The facts set forth in my application are true and complete. I understand that false statements on this application shall be considered sufficient cause for rescinding membership. **YOU MUST SIGN YOUR APPLICATION:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_