

**CANADIAN SOCIETY OF CLINICAL HYPNOSIS**

**(BC DIVISION)**

**2036 West 15<sup>th</sup> Avenue**

**Vancouver, BC V6J 2L5**

**Phone # (604) 688-1714 / Fax # (604) 683-6979 / Email: admin@hypnosis.bc.ca**

**MEMBERSHIP APPLICATION**

**NAME:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**1. Office Address:**

\_\_\_\_\_  
\_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ / Email Address \_\_\_\_\_

**2. Home Address:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**3. If membership is granted, the address and phone number I would like listed in the Society Directory is my (please pick only one):**

\_\_\_\_\_ Office Address/Phone      \_\_\_\_\_ Home Address/Phone

**4. Highest Professional Degree earned:**

\_\_\_\_\_

This Degree was earned from what Educational Body: \_\_\_\_\_

\_\_\_\_\_

**5. If membership is granted, the other Degrees I would like listed in the Society Directory are:**

\_\_\_\_\_

\_\_\_\_\_

(Please use abbreviations only)

**6. I am licensed or certified in British Columbia as a:**

| <b><u>Profession</u></b>          | <b><u>License or Registration #</u></b> | <b><u>Profession</u></b>       | <b><u>License or Registration #</u></b> |
|-----------------------------------|---|--------------------------------|---|
| Physician                         | _____                                   | Social Worker                  | _____                                   |
| Dentist                           | _____                                   | Nurse                          | _____                                   |
| Psychologist                      | _____                                   | Marriage & Family<br>Therapist | _____                                   |
| Registered Clinical<br>Counsellor | _____                                   | Other                          | _____                                   |

7. I have completed my basic training in clinical hypnosis:  YES  NO

Sponsoring Organization: \_\_\_\_\_

Place/Date: \_\_\_\_\_

Number of Hours: \_\_\_\_\_

Please submit a certificate of attendance with your application. If you have not completed basic training, you will be required to do so within one year of approval of your membership application. Please see Membership Eligibility for particulars of training requirements.

8. I wish to apply for membership in the following category:

Full ; Associate: ; Student\* ; or Special Affiliate:

\* Note: Student applicants must provide proof of student status.

9. I am a member of the American Society of Clinical Hypnosis:  Yes  No

10. If membership is granted, do you plan to accept referrals?  Yes  No

Please note that students will not be listed as accepting referrals.

11. If you are accepting referrals, please indicate what areas you will be offering treatment. This will be listed in the directory under Specialty.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that the above information is complete and accurate and agree to abide by the Constitution of the Canadian Society of Clinical Hypnosis (B.C. Division).

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

Annual Dues:           **\$110 Full, Associate & Special Affiliate Membership**  
                              **\$25 Student Membership**

I have enclosed:        my cheque for membership dues;  
                               documentation of introductory workshop;  
                               if applying for student membership, proof of student status.

**\*WOULD YOU LIKE YOUR INFORMATION LISTED ON OUR WEBSITE FOR REFERRALS?**    Yes or  No

**\*WOULD YOU LIKE YOUR WEBSITE ADDRESS LINKED WITH OUR WEBSITE?**        Yes or  No