

The Canadian Society of Clinical Hypnosis - Ontario Division

APPLICATION FOR MEMBERSHIP

Please read the website (www.hypnosisontario.com) for details on eligibility, and print clearly.

I wish to apply for membership in the following category:

- Member Intern or Resident Member ¹

¹ *Student applicants must provide verification of relevant full-time student status.*

NAME: (include your preferred title - Dr. Mr. Mrs. Ms. etc.)

Main Address

_____ Postal Code: _____

Phone #: () _____ Email: _____

This is my: Office Home Other

All CSCH official correspondence will be e-mailed to Main address.

Optional Alternate Address:

_____ Postal Code: _____

Phone #: () _____ Email: _____

This is my: Office Home Other.

You may want to provide an alternate address for us to give with referrals, or for the members-only directory.

Your Degrees ²: _____

New: Member Directory to be found in the Member area of the CSCH-OD website.

New: No, I do not wish to be listed on the CSCH-OD Member Directory.

New: Yes, I wish to be listed on the CSCH-OD Member Directory. Please indicate **only** the information to be published: email, phone, address (kindly write out the specific information):

How do you describe what you “do”? Your specialty, profession, occupation or whatever. Examples would be: Family Doctor, Psych Associate, Gynaecologist, Social Worker, Nurse-Therapist, etc. (for lack of a better term, we call this data “profession”.)

Profession

Licence Number ² (for the College indicated in the next column)

Which College regulates your professional work? If you belong to more than one, check the one under whose auspices you do the majority of your work:

- Chiropractors
 - Dental Surgeons
 - Nurses
 - Occupational Therapists
 - Physicians and Surgeons
 - Physiotherapists
 - Psychologists
 - Other RHPA College (specify below)
- _____
- Social Workers
 - Psychotherapists
 - Out of Province College (specify below)
- _____

² Please submit supporting documentation for your highest degree and your licensure

I have completed my basic training in clinical hypnosis ³:

Sponsoring Organization: _____
Place/Date: _____
Number of Hours: _____

³ Please submit supporting documentation of your hypnosis training.

Referrals

Please note that only Full Members and Fellows are listed as accepting referrals.

Currently, referrals are handled centrally and the contact data you provide is sent by e-mail to the prospective client. Future plans call for a web-based database which prospective clients will query directly. If membership is granted, do you plan to accept referrals for hypnotherapy?

Yes No

Are you willing to have your name, contact information and specialty areas of hypnosis treatment provided to clients, in cases where their request matches your areas of practice and geographic location?

Yes No

Which contact information shall we provide to clients?

Main Alternate

If you will be accepting referrals, please fill in the attached referral sheet (Page 4).

Referral Information sheet

(Submit only if you want to accept referrals – full members and fellows only)

Your name: _____

Which of the following conditions do you **have training & experience in treating** and for which you would receive referrals?

- | | |
|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Addictions |
| <input type="checkbox"/> Age Regression | <input type="checkbox"/> Anger Management |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Bedwetting Children |
| <input type="checkbox"/> Bereavement | <input type="checkbox"/> Childhood Trauma |
| <input type="checkbox"/> Conversion Disorder | <input type="checkbox"/> Couple Therapy |
| <input type="checkbox"/> Chronic / Terminal Illness | <input type="checkbox"/> Dental Phobias |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Dissociative Disorders |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Ego Strengthening |
| <input type="checkbox"/> Forensic Issues | <input type="checkbox"/> Group Therapy |
| <input type="checkbox"/> Habits (e.g., thumb-sucking) | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Health Promoting Behaviours | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Hypnoanalysis | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Obsessive Compulsive Disorders | <input type="checkbox"/> Obstetrical Delivery |
| <input type="checkbox"/> Pain - Acute | <input type="checkbox"/> Pain - Chronic |
| <input type="checkbox"/> Panic Disorder | <input type="checkbox"/> Performance Enhancement-Sport |
| <input type="checkbox"/> Phobias | <input type="checkbox"/> Posttraumatic Stress Disorder |
| <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Self Injurious Behaviours |
| <input type="checkbox"/> Self Esteem | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Sexual Trauma | <input type="checkbox"/> Sexual Orientation |
| <input type="checkbox"/> Skin Problems & Rashes | <input type="checkbox"/> Sleeping Disorders |
| <input type="checkbox"/> Smoking Cessation | <input type="checkbox"/> Stress Management & Relaxation |
| <input type="checkbox"/> Weight Loss | |

Do you work with:

- Children younger than 5
- Children older than 5
- Adolescents
- Adults
- Geriatrics

What other conditions would you like to see as categories in this list?