The Canadian Society of Clinical Hypnosis - Ontario Division

APPLICATION FOR MEMBERSHIP

Please read the website (www.csch-od.ca) 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-OD 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:] _____

I am currently a member of ASCH: Yes _____ No _____

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

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

□ 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).

Declaration

I declare that I am a member in good standing with my regulatory college.

I certify that the above information is complete and accurate and agree to abide by the Bylaws, Resolutions and Orders of the Canadian Society of Clinical Hypnosis (Ontario Division).

Date: _____ Signature: _____

Please send application, payment and documentation to:

Nikita Patel (admin@csch-od.ca)
CSCH-OD Membership
705, 20 Aurora Crt
Scarborough, Ontario
M1W 2M2

N.B. The fee includes a $25 non-refundable processing fee for all applications.

DOCUMENTATION and PAYMENT REQUIRED: (Please check off)

Payment:

- ☐ $160.00 for Member status or ($135 Early Bird offer while available)
- ☐ $130.00 for Associate Member status or
- ☐ $30.00 for Intern and Resident Membership
- ☐ plus $65.00 for the SCEH Journal (optional, offer closes Feb 3rd each year)
- ☐ I have enclosed a credit to reduce this amount by $ _____

Total Amount: $ _____

via

- ☐ Cheque (payable to CSCH-OD) or
- ☐ I have already paid by online payment or
- ☐ Credit Card:

☐ Visa ☐ MasterCard

Card Number Expiry: MM YY

Three digit security code (back of card) Appears after and to the right of your card number CSC

I have enclosed:

- ☐ Documentation of degree - required
- ☐ Documentation of licensure - required
- ☐ Documentation of attendance at an Introductory Workshop – required
- ☐ Verification of full-time student status - required If applying for Intern and Resident membership

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?

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

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?