



Canadian Society of Clinical Hypnosis - Ontario Division

Intermediate Workshop Registration Form

Dates: November 6 and 7 2026

Registration Details

Email Address (required): _____

Mailing Address: _____

Home address Office address

Phone Number: _____

Highest Degree: _____

I qualify for the member's rate because I belong to CSCH: _____

Introductory Hypnosis Training

Organization: _____ Year: _____

Check one:

I am a licensed, registered professional

College: _____ (e.g., OCSWSSW, CPO, CPSO, CNO, CRPO, etc.)

Registration/Licence Number: _____

I am a student or medical resident (proof of enrollment attached)

Course & School: _____

Graduation/Completion Date: _____

I confirm the accuracy of the information provided and for CSCH-OD correspondence.

Registrant's Signature: _____

Payment Details:

Title: Dr. Mr. Mrs. Ms.

Name: _____

Payment Method

Cheque Enclosed Visa MasterCard Already paid online



Canadian Society of Clinical Hypnosis - Ontario Division

Card Number: _____

Expiry Date (MM/YY): ____ / ____

Security Code (CVV): ____

Amount Paid/Authorized: \$ _____

Cheques payable to Canadian Society of Clinical Hypnosis-Ontario Division

(No post-dated cheques please.)

Mail to: 1920 Ellesmere Road, Suite 208, Scarborough, Ontario, M1H 2V6