



APPLICATION FOR MEMBERSHIP – NEW MEMBERS

302, 3939-50A Avenue
 Red Deer, Alberta
 Canada T4N 4E5
Phone 1-800-386-7230
Fax
Email alberta.office@clinicalhypnosis.ca
Website www.clinicalhypnosis.ca/Alberta/

I WISH TO APPLY FOR MEMBERSHIP IN THE FOLLOWING CATEGORY:

MEMBER AFFILIATE STUDENT*

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

PERSONAL INFORMATION

LAST NAME		FIRST NAME			DEGREE (highest earned)	
OFFICE ADDRESS	SUITE #	STREET ADDRESS	CITY	PROVINCE	POSTAL CODE	
HOME ADDRESS	SUITE #	STREET ADDRESS	CITY	PROVINCE	POSTAL CODE	
CONTACT INFO	PHONE #	FAX #	EMAIL (primary used by office)			

WHICH ADDRESS DO YOU WANT LISTED IN THE MEMBERSHIP DIRECTORY?

Office Home

PROFESSIONAL INFORMATION

I AM LICENSED OR CERTIFIED AS A:

PROFESSION

LICENSE #

Please provide a photocopy confirming your registration, certification or licensure.

- Dentist
- Marriage & Family Therapist
- Nurse
- Physician
- Psychologist
- Social Worker
- Other (please specify) _____

I HAVE COMPLETED INTRODUCTORY TRAINING IN CLINICAL HYPNOSIS:

Yes No

Please include documentation.

Applicants are invited to submit their applications if they believe they meet all requirements for admission to the Society with the exception of completion of a basic workshop. If accepted these applicants have two years to complete an introductory workshop acceptable to the Society.

SPONSORING ORGANIZATION

PLACE/DATE:

OF HOURS:

TYPE OF INVOLVEMENT (IF ANY) IN THE AMERICAN SOCIETY OF CLINICAL HYPNOSIS (ASCH):

Member Fellow Approved Consultant

REFERRAL INFORMATION

DO YOU PLAN TO ACCEPT REFERRALS FOR HYPNOTHERAPY?

Yes No

Please note that only full members will be listed as accepting referrals.

IF YOU ARE ACCEPTING REFERRALS, IN WHAT AREAS WILL YOU BE OFFERING TREATMENT?

Please note that this Information will be listed in the directory under Referral Area.

(For Example: Dental Anxiety; Smoking Cessation; Anxiety Management; Depression; Habit Control)

RELEASE INFORMATION

I GIVE PERMISSION TO THE SOCIETY TO RELEASE CONTACT INFORMATION ABOUT ME TO:

** You must check "Yes" if you want referrals from the Society's office.*

General Public *

Yes No

Society Members

Yes No

Prospective Members

Yes No

I certify that the above information is complete and accurate and agree to abide by the Bylaws, Resolutions, and Orders of the Canadian Federation of Clinical Hypnosis - Alberta Society.

SIGNATURE

DATE

PLEASE SEND APPLICATION TO:

Membership Chairperson
Canadian Federation of Clinical Hypnosis – Alberta Society
302, 3939-50A Avenue
Red Deer, AB T4N 4E5

I HAVE ENCLOSED A CHEQUE* FOR:

** Please make cheque payable to Canadian Federation of Clinical Hypnosis - Alberta Society*

- \$135 Member
- \$110 Affiliate Member
- \$ 65 Student Member

I HAVE ATTACHED THE FOLLOWING:

- Photocopy of degree
- Copy of current registration, certification or licensure
- Documentation of attendance at an Introductory Workshop
- If applying for student membership, verification of full-time student status

OFFICE USE ONLY

	DATE	COMMENT
RECEIVED	_____	_____
APPROVED	_____	_____
NOTATION/COMMENTS	_____	