

The Canadian Society of Clinical Hypnosis (Ontario Division)

Mission Statement: To promote the use of clinical hypnosis by regulated health professionals in the therapeutic treatment of individuals through education and training, collegial support among clinicians, and liaison with other professional hypnosis societies, in a manner consistent with the highest standards of ethical practice.

INFORMATION ABOUT THE SOCIETY

The Canadian Society of Clinical Hypnosis – Ontario Division is a new association of clinicians who use hypnosis to improve the health and well being of their clients and patients. The Ontario Division is a component of the Canadian Federation of Clinical Hypnosis (CFCH) with Alberta, Nova Scotia and Quebec.

Members are entitled to reduced registration fees at conferences and workshops in Ontario and other divisions of the Canadian Federation of Clinical Hypnosis.

Members will receive a certificate of membership and will be listed in the Society's directory.

MEMBERSHIP INFORMATION

Membership is open to individuals in Regulated Health Professions (e.g., medicine, dentistry, psychology, chiropractic, social work, and nursing) or students working towards one of these degrees.

In order to become a member of the Society, applicants must take a basic training workshop run by the Society, another component section of CFCH, ASCH, or a course approved by the Membership Committee.

Introductory courses must offer direct supervision and practice in hypnotic techniques and clinical applications. Prospective members must also hold (or be a student working towards) one of the previously mentioned degrees and be in good standing with their related professional certifying body.

Annual dues are **\$150.00/year** for full members, **\$120/year** for associate members, **\$100/year** for affiliate members and **\$25.00/year** for students. Please note that as of 2008 our membership year changed from April 1 to March 31 to January 1 to December 31.

MEMBERSHIP CATEGORIES

A) Members

- i. Persons having earned a doctorate (or equivalent) in medicine, dentistry or chiropractic, the minimum of a masters degree in psychology, social work, or nursing, and who
- ii. Are members in good standing of a regulatory college, and who
- iii. Evidence professional training and experience in clinical or experimental hypnosis acceptable to the Membership Committee.

B) Fellows

- i. A Fellow shall have met all the requirements for membership in CSCH-OD, have been a member for three years, and have made a significant contribution to the Society and/or demonstrated exceptional achievement in the field of clinical hypnosis, and
- ii. Been recommended by the Executive Committee.

C) Honorary Life Members

Honorary Life Membership shall be accorded to persons who have been of outstanding assistance to the Society upon recommendation of the Executive Committee.

D) Associate Members

- i. Associate Members shall be limited to those individuals who meet all the academic and professional criteria for full membership, but have not completed the required hypnosis training;
- ii. Full membership is granted to an Associate Member upon completion of the training deemed appropriate by the Membership Committee chair; and;
- iii. An Associate Member has all the privileges of membership except those of voting, holding office, acting as chair of a committee, or receiving referrals from the Society.

E) Student Members

- i. Persons who are enrolled full time in a masters or doctorate degree program in medicine, dentistry, psychology, social work, chiropractic or nursing and who
- ii. Evidence professional training and experience in clinical or experimental hypnosis acceptable to the Membership Committee.
- iii. Student membership shall be granted for a maximum of two years at a time. At the end of two years, the Membership Committee will review Student membership.
- iv. Would not be eligible to vote, hold office, chair committees or accept referrals from CSCH-OD.

F) Affiliate Members

Affiliate Members shall be limited to those healthcare providers in good standing with their respective healthcare licensing/registration body, who do not meet all the qualifications for any of the existing categories, but whose contributions, interests, or training would justify membership.

The following process is recommended for processing an application for Affiliate Membership:

1. Any three or more Members and/or Fellows may nominate any person who provides healthcare to be an affiliate member.

The nominations must:

- a. be in writing and signed by the nominating Members or Fellows
 - b. be provided to the Chair of the Membership Committee,
 - c. indicate the name, address, and occupation of the nominee,
 - d. provide proof that the nominee is in good standing with his/her Healthcare Licensing or Registration body,
 - e. set out the contributions, interests, or training of the nominee that justify Affiliate Membership, and
 - f. provide the written consent of the nominee that the information in the nomination is correct.
2. The Membership Committee shall consider each nominee and decide whether or not to recommend the nominee be made an Affiliate Member. The Membership Committee shall provide the Executive Committee the nominations of those nominees it recommends for Affiliate Membership and the reasons for its recommendations
 3. The Executive Committee is to consider the recommendation of the Membership Committee and to decide whether or not to admit the nominee to Affiliate Membership. The Executive Committee is to advise each nominee it chooses to admit to Affiliate Membership.
 4. The Executive Committee shall report at the annual general meeting of the CSCH-OD the names of all persons admitted to Affiliate Membership.

An Affiliate member has all the privileges of membership except those of voting, holding office, acting as chairperson of a committee, or receiving referrals from CSCH-OD.

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APPLICATION FOR MEMBERSHIP

(Please print clearly)

NAME: _____

1. Office Address: _____

_____ Postal Code: _____

Phone #: () _____ Fax #: () _____

Email: _____

2. Home Address: _____

_____ Postal Code: _____

Phone #: () _____ Fax #: () _____

Email: _____

3. Preferred Mailing Address, Fax and E-Mail: Office **or** Home

4. **DEGREE** (highest earned): _____

5. * I am licensed in Ontario as a:

Profession

License #

- | | |
|--|-------|
| <input type="checkbox"/> Chiropractor | _____ |
| <input type="checkbox"/> Dentist | _____ |
| <input type="checkbox"/> Physician | _____ |
| <input type="checkbox"/> Psychologist | _____ |
| <input type="checkbox"/> Psychological Associate | _____ |
| <input type="checkbox"/> Social Worker | _____ |
| <input type="checkbox"/> Nurse | _____ |
| <input type="checkbox"/> Occupational Therapist | _____ |
| <input type="checkbox"/> Physiotherapist | _____ |
| <input type="checkbox"/> Dental hygienist | _____ |
| <input type="checkbox"/> Other _____ | _____ |

* Please submit supporting documentation with your application

6. * I have completed my basic training in clinical hypnosis:

Sponsoring Organization: _____

Place/Date: _____

Number of Hours: _____

* Please submit supporting documentation with your application.

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

Member Associate Member Affiliate Member * Student Member

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

8. Please indicate type of involvement (if any) in other hypnosis organizations (e.g. ASCH)

I am a ... Member Fellow Approved consultant Other

in _____

Membership #: _____

9. If membership is granted, what address and phone number do you want listed in the Membership Directory?

Office **or** Home

10. If membership is granted, do you plan to accept referrals for hypnotherapy?

Yes No

11. Are you willing to have your name, contact information and specialty areas of hypnosis treatment published on our website?

Yes No

Please note that students, associate, and affiliate members will not be listed as accepting referrals.

12. If you are accepting referrals, please fill in the attached referral sheet. **Remember – this will be listed in the directory (and website if permission given above) under Referral Area.**

Canadian Society of Clinical Hypnosis - Ontario Division

Hypnosis Referral Sheet

Only Complete If You Want Hypnosis Referrals

(Only Full Members Are Eligible to Receive Referrals)

Name:

Address:

Phone Number: Home () Office ()

Fax ()

e-mail

Are you willing to have your name & contact information in a Referral Directory? Yes No

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"/> Couple Therapy | <input type="checkbox"/> Chronic / Terminal Illness |
| <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., thumbsucking) | <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"/> Smoking Cessation |
| <input type="checkbox"/> Stress Management & Relaxation | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Dental Phobias | <input type="checkbox"/> Dental Other: _____. |
| <input type="checkbox"/> Other: _____. | <input type="checkbox"/> Other: _____. |

Do you work with:

- Children: Younger than 5 Older than 5 Adolescents Adults
- Geriatrics Other Special Populations: _____

13. 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 to: Dr. Jacques J. Gouws, C.Psych.
Membership Chair, CSCH-OD
29 Renata Court
Dundas Ontario
L9H 6X1 Canada

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

DOCUMENTATION REQUIRED: (Please check off)

I have enclosed: _____ Cheque* in the amount of
 _____ **\$150.00** for **Member** status;
 _____ **\$120** for **Associate Member** status;
 _____ **\$100.00** for **Affiliate Member** status, or
 _____ **\$25.00** for **Student Membership**
 _____ Documentation of degree
 _____ Documentation of licensure
 _____ Documentation of attendance at an Introductory Workshop
 _____ If applying for student membership, verification of full-time student status

*No post dated cheques, please.

Board of Directors

| | |
|--|--|
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