THE MINNESOTA SOCIETY OF CLINICAL HYPNOSIS
MEMBERSHIP APPLICATION/RENEWAL FORM

Membership Category: **FULL MEMBERS** are licensed to practice in the state in which they reside and have attained either a master's or a doctoral degree. **ASSOCIATE MEMBERS** are full-time students, health care professionals completing coursework or supervised experience toward licensure, or licensed health care professionals holding lower than a master's degree. All licensed members must be in current good standing with their licensing board.

SECTION 1 – TO BE COMPLETED BY ALL APPLICANTS

____**RENEWING MEMBER** ____**FULL** ($70.00)

____**NEW APPLICANT** ____**ASSOCIATE** ($60.00)

NAME: _____ _____
Last First Middle Initial Degree

BUSINESS ADDRESS: _____
Street City State Zip

PHONE: Work ( )_____ Home ( ) _____ Cell ( ) _____ Fax ( ) _____

EMAIL ADDRESS: _____

PROFESSIONAL LICENSES:

_____
States Types Numbers

Have you ever been denied a license, or had your license revoked, suspended, or restricted?
_____ Yes If yes, please attach supplement providing details _____ No

Are you a member of American Society of Clinical Hypnosis (ASCH)? _____Yes _____ No

Professional Uses of Hypnosis: Please see back and check the designation(s) that best indicate(s) your speciality.

SECTION 2 – TO BE COMPLETED BY NEW APPLICANTS OR ASSOCIATE MEMBERS REQUESTING FULL MEMBERSHIP

Are you an Associate Member Requesting Full Membership? _____Yes _____No

EDUCATION

Baccalaureate: _____
Institution Degree Date

Graduate: _____
Institution Degree Date (Anticipated)

_____
Institution Degree Date (Anticipated)

HYPNOSIS TRAINING

Introductory: _____
Course Location Year

Advanced: _____
Course Location Year

Please attach documentation of completion and syllabus if the training was not approved by MSCH or ASCH.

I affirm that the statements made in this application are correct and understand that if they are not, my affiliation with MSCH may be terminated. I understand that hypnosis should only be utilized in accordance with the skills and practices for which I am licensed and certified.

APPLICANT SIGNATURE: _____ **DATE:** _____

PLEASE SEND RENEWAL APPLICATION TO:
MSCH, Att: Deb Schrobilgen ▪ PO Box 755 ▪ Prior Lake, MN 55372-0755 (schro451@umn.edu)

PLEASE SEND NEW APPLICATION TO:
Shep Myers, PhD
Fairview Pain Management Center, U of MN Medical Center ▪ 606 24th Ave S Ste 600 ▪ Minneapolis, MN 55454-5020 (smyers1@gmail.com)

SPECIALIZATIONS CODES

SPECIALIZATION	CODE	CHECK ALL THAT APPLY TO YOUR SPECIALTY
Addiction	ADD	
Adolescent Medicine	ADL	
Anxiety	ANX	
Behavioral Medicine	BM	
Cancer	CAN	
Child Abuse	CA	
Chronic Illness	CHD	
Chemical Dependency	CD	
Mood Disorders	DEP	
Dentistry	DE	
Dissociative Disorders	DD	
Ego Strengthening	EGO	
GI Disorders	GI	
Habit Control	HC	
Labor/Delivery	LD	
Pain Management	PM	
Pediatrics	PED	
Posttraumatic Stress Therapies	PTSD	
Preparation for Medical Procedures	PP	
Psychophysiological Disorders	PSY	
Regression	REG	
Sports/Performance Enhancement	SPM	
Sexual Abuse	SA	
Stress Management	SM	
Women's Health	WH	

____ Yes, I want my name in both the printed and the on-line directories.

____ No, I do not want to be listed on the web site. I only want my name in the printed directory for members.

In the interest of "going green," effective July 1, 2010, all notices of events and other organizational information will be sent by e-mail. The fiscal year for MSCH runs from July through June. While people may renew their membership at any time, the renewal runs only to the end of each fiscal year. Therefore, individuals who choose to renew well into the fiscal year are required to renew again at the start of the following fiscal year for their membership to remain active.