

**Georgia Hypnosis Society
Membership Application**

A component section of the American Society of Clinical Hypnosis
(Please print)

Name: _____ Highest degree acquired: _____

Office address: _____

_____ (City) (State) (Zip)

Office phone: (____)____-____ Ext. ____ Fax phone: (____)____-____

E-mail: _____ Website: _____

Profession: _____ License #: _____ State: _____

_____ Licensed as: _____

Colleges/Universities attended:

(University) (Degree) (Year obtained) (University)

(University) (Degree) (Year obtained) (University)

Publications: (or attach vita)

Teaching affiliations (past and present):

Hypnosis training: (Please include a sample of courses, workshops, conferences, research, books read, etc.)

Are you a member of ASCH: Yes [] No []

Are you interested in becoming a member of ASCH (Am Society of Clinical Hypnosis): Yes [] No []

Other organizational affiliations:

Briefly explain how you use hypnosis in your profession/practice: _____

What would you like to get from being a member of GHS? _____

With which of the following might you be willing to assist?

- Membership acquisition and retention
- Organizing workshops and continuing education
- Public relations
- Presentations at GHS meetings/CE workshops
- Website maintenance

If you would like to speak at an GHS meeting or workshop, what topics would you like to address? _____

Please note topics relative to hypnosis in which are you interested in learning more:

Please list any colleagues or friends whom you would like us to contact about membership interest in GHS?

(Name) (____)____-____ Ext. ____
(Phone)

(Name) (____)____-____ Ext. ____
(Phone)

(Name) (____)____-____ Ext. ____
(Phone)

Annual Membership Dues are \$20.00. Please enclose a check payable to *Georgia Hypnosis Society*. Mail your completed application to:

Marvin S. Goldstein, Ph.D.
4651 Chamblee-Dunwoody Rd., Suite D
Atlanta, GA 30338

**Georgia Hypnosis Society
Web Site Referral Information**

Name: _____
Address: _____

City: _____ State: ____ Zip Code: _____
Phone: (____) _____ - _____ Ext: _____
E-mail: _____
(Please print *very* carefully)

Web site: **www.**_____.

2nd office information:

Address: _____

City: _____ State: ____ Zip Code: _____
Phone: (____) _____ - _____ Ext: _____

Ages served:	<input type="checkbox"/> preschool	Therapy with:	<input type="checkbox"/> individual
	<input type="checkbox"/> children		<input type="checkbox"/> couples
	<input type="checkbox"/> teenagers		<input type="checkbox"/> families
	<input type="checkbox"/> adults		<input type="checkbox"/> groups
	<input type="checkbox"/> geriatric		<input type="checkbox"/> business settings

Presenting Concerns:

<input type="checkbox"/> addiction
<input type="checkbox"/> anxiety
<input type="checkbox"/> dental
<input type="checkbox"/> depression
<input type="checkbox"/> headaches
<input type="checkbox"/> mood disorders
<input type="checkbox"/> pain
<input type="checkbox"/> past life therapy
<input type="checkbox"/> phobias
<input type="checkbox"/> smoking cessation
<input type="checkbox"/> stress
<input type="checkbox"/> surgery
<input type="checkbox"/> TMJ
<input type="checkbox"/> trauma/PTSD
<input type="checkbox"/> weight loss

License # and Licensing Board

Malpractice insurance \$ _____ / \$ _____

(Insurance info will not be posted on website.)

Please list memberships and status you would like included: (e.g., ASCH, Approved Consultant)

I attest that the above information is true and accurate.

Signed _____ Date _____

(what other categories would you like to see listed?)

