

Oregon Society of Clinical Hypnosis  
Membership Application and Referral Information

OSCH is composed of professionals in the healing arts who use hypnosis in their clinical practice.  
We are interested in promoting the use of hypnosis through education and professional development.

Name: \_\_\_\_\_ Degree: \_\_\_\_\_

Address: Office \_\_\_\_\_

Address: Mailing, if different: \_\_\_\_\_

Telephone: Office: \_\_\_\_\_ Home or cell: \_\_\_\_\_

E-mail: \_\_\_\_\_

Is address, telephone, email a change from last year?  yes  no  not sure

Board/License/Certification #: \_\_\_\_\_ Member of ASCH?  yes  no

Type of Practice: \_\_\_\_\_

Briefly outline your training and experience with clinical hypnosis (continue on reverse if needed):

Membership category:  Renewal Year of initial membership in PAH or OSCH: \_\_\_\_ (if you recall)

New  Associate  Retired  Life  Student (\*please obtain institutional signature below)

**Do you wish to be listed on our web-based referral page?**  yes  no (www.oregonhypnosis.org)

**Referrals can only be made based on this year's information.**

If you wish to receive client referrals, please indicate below the areas of your practice:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Addictions                         | <input type="checkbox"/> Forensic work                  | <input type="checkbox"/> Post traumatic stress disorder        |
| <input type="checkbox"/> Allergy                            | <input type="checkbox"/> Learning enhancement           | <input type="checkbox"/> Pre-operative analgesia/anesthesia    |
| <input type="checkbox"/> Amnesia/lost objects & information | <input type="checkbox"/> Mood disorders                 | <input type="checkbox"/> Sexual abuse/Trauma                   |
| <input type="checkbox"/> Anxiety                            | <input type="checkbox"/> Motivational Development       | <input type="checkbox"/> Sleep/Insomnia                        |
| <input type="checkbox"/> Bruxism                            | <input type="checkbox"/> Pain management                | <input type="checkbox"/> Smoking cessation                     |
| <input type="checkbox"/> Childbirth preparation             | <input type="checkbox"/> Panic attacks                  | <input type="checkbox"/> Stress management                     |
| <input type="checkbox"/> Compulsive behaviors               | <input type="checkbox"/> Performance Enhancement        | <input type="checkbox"/> Stuttering                            |
| <input type="checkbox"/> Dental issues: anxiety, analgesia  | <input type="checkbox"/> Smoking cessation              | <input type="checkbox"/> Temporomandibular Disorders (TMD/TMJ) |
| <input type="checkbox"/> Depression                         | <input type="checkbox"/> Sports                         | <input type="checkbox"/> Weight management                     |
| <input type="checkbox"/> Dissociative disorders             | <input type="checkbox"/> Public speaking                | <input type="checkbox"/> Other                                 |
| <input type="checkbox"/> Eating disorders                   | <input type="checkbox"/> Other                          |  |
|   | <input type="checkbox"/> Phobic disorders               |  |
|   | <input type="checkbox"/> Physiologic symptom management |  |

Do you treat:  Children  Adolescents  Adults

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

\*Student member: Faculty or registrar signature, institution, and telephone:

\_\_\_\_\_  
Please mail this membership and referral Form with the annual dues of \$70.00 (\$60 if paid before November 1); \$40 for student/resident or retired status. Please make checks payable to OSCH.

OSCH  
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