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?

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

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

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

Annual Membership Dues are $39.00. Please enclose a check payable to *Georgia Hypnosis Society*. Mail your completed application to:

Mail to: Laura B. Temin, LMFT, LPC, DCC, BCC.
1025 Old Roswell Road Suite 103
Roswell, GA 30076

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:
[ ] preschool
[ ] children
[ ] teenagers
[ ] adults
[ ] geriatric

Therapy with:
[ ] individual
[ ] couples
[ ] families
[ ] groups
[ ] business settings

Presenting Concerns:
[ ] addiction
[ ] anxiety
[ ] dental
[ ] depression
[ ] headaches
[ ] mood disorders
[ ] pain
[ ] past life therapy
[ ] phobias
[ ] smoking cessation
[ ] stress
[ ] surgery
[ ] TMJ
[ ] trauma/PTSD
[ ] weight loss

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

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

Mail to: Laura B. Temin, LMFT, LPC, DCC, BCC.
1025 Old Roswell Road Suite 103
Roswell, GA 30076
GHS Website Referral Form 2015