Hello Prospective Clinical Member:

The Society is an international organization of psychologists, physicians, psychiatrists, dentists, social workers and master's level nurses and other professionals who are dedicated to the highest level of scientific inquiry and the conscientious application of hypnosis in two settings; clinical and experimental.

Full membership is available to health care professionals with an earned degree as MD, DO, DDS, DMD, MB ChB, PhD, EdD, PsyD, MSW, DSW, an NP or PA or a similar degree acceptable to the Executive Committee or the Board of SCEH from a regionally- or nationally-accredited university or Training Institution, or status as a registered and licensed practitioner in healthcare such as RN, RTR, registered medical technologist or technician. All applicants shall be licensed in the state or province where they practice. If you are a research academician, please apply for Experimental Membership.


Evidence of training or competence in hypnosis research and/or teaching:
Clinical Applicants must have completed, or plan to complete, an acceptable 20 hour introductory course in hypnosis at or before the next Annual SCEH meeting. The introductory course can be one sponsored by SCEH, The American Society of Clinical Hypnosis or one of its component societies, The International Society of Hypnosis or a related organization or university. Applicants need not submit copies of research articles.

Recommendations from two professionals who are familiar with the applicants’ experimental and/or academic work must also be submitted. Please use the enclosed recommendation form.

If there is any further information I can provide to you or if you have any questions, please do not hesitate to contact me at the above address. Thank you for your interest.

Sincerely,

Michele Hart
Executive Director
List of Specialties

Choose up to three of the following specialties to be listed in the directory

A  Allergy
ADD  Addictions
ADL  Adolescent Medicine
AM  Aerospace Medicine
ANES  Anesthesia
ANX  Anxiety
APM  Pain Management, (Anesthesiology)
BM  Behavioral Medicine
C  Cardiovascular Disease
CA  Child Abuse
CBT  Cognitive Behavioral
CC  Clinical Child Psychology
CD  Chemical Dependency
CHI  Chiropractic
CHP  Child Psychology
CLP  Clinical Psychology
COL  Counseling Psychology
D  Dermatology
DD  Dissociative Disorders
EM  Emergency Medicine
EN  Endodontia
FO  Forensic
FMP  Family, Marriage, Psychology
FP  Family Practice
FT  Family Therapist
G  Gynecology
GD  General Dentistry
GA  Gastroenterology
GE  Geriatrics
GP  General Practice (in their own profession)
GPM  General Preventive Medicine
HYP  Hypnotherapy (Practice Specialized in Hypnotherapy)
IM  Internal Medicine
IND  Industrial Medicine
LCSW  Licensed Clinical Social Work
MFT  Marriage and Family Therapist
N  Neurology
NS  Neurological Surgery
OB  Obstetrics
OBG  Obstetrics, Gynecology
OM  Occupational Medicine
ON  Oncology
OPH  Ophthalmology
ORS  Orthopedic Surgery
ORD  Orthodontia
OS  Oral Surgery
OSM  Sports Medicine, (Orthopedic Surgery)
OT  Otology
OTO  Otolaryngology
P  Psychiatry
PD  Pediatrics
PDT  Podiatry
PEM  Pediatric Emergency Medicine
PER  Periodontia
PH  Public Health
PNM  Pain Management
PN  Psychiatry, Neurology
POD  Pedodontia
PR  Proctology
PSY  Psychotherapy
PT  Psychology Therapy
PTH  Post Trauma Healing
PTSD  Post Traumatic Stress Syndrome
PUL  Pulmonary Disease
R  Roentgenology, Radiology
REH  Rehabilitation
S  Surgery
SA  Sexual Abuse
SM  Stress Management
SP  Sport Psychology
ST  Sexual Trauma
TCM  Traditional Chinese Medicine
TS  Thoracic Surgery
U  Urology
REQUIREMENTS FOR CLINICAL MEMBERSHIP:

1. An earned degree as MD, DO, DDS, DMD, MB ChB, PhD, EdD, PsyD, MSW, DSW, an NP or PA or a similar degree acceptable to the Executive Committee or the Board of SCEH from a regionally- or nationally-accredited university or Training Institution, or status as a registered and licensed practitioner in healthcare such as RN, RTR, registered medical technologist or technician. All applicants shall be licensed in the state or province where they practice.


3. Evidence of training or competence in hypnosis research and/or teaching. Clinical Applicants must have completed, or plan to complete, an acceptable 20 hour introductory course in hypnosis at or before the next Annual SCEH meeting. The introductory course can be one sponsored by SCEH, The American Society of Clinical Hypnosis or one of its component societies, The International Society of Hypnosis or a related organization or university. Applicants need not submit copies of research articles.

4. Recommendations from two professionals who are familiar with the applicants experimental and/or academic work. Please use the recommendation form in the application. Please use the attached recommendation form.

Identification and contact

Name

First Middle Initial Last Degree

Professional Affiliation

Mailing Address

City State Zip Country

Day Telephone Fax E-mail

Do you want your email available for referral and in future SCEH directories?  □ Yes  □ No

Education

Most advanced degree Field in which degree was granted

University (name, city and state) Year granted

Present position (specify title or rank, institution and dates or attach C.V)

Field of licensure or certification Date of licensure or certification #
Please enclose a copy of a current licensure or certification

OPTIONAL Specialty, if any, using the specialization codes with this applications (1) (2) (3)

Specialization Certified by ___________________________ Date ___________________________

Professional Memberships

Honorary Societies ___________________________

Are you a Diplomat of an American or European Board? □ Yes □ No

If you checked “Yes,” please list which board ___________________________

Social Workers, indicate number of hours post-Master supervised clinical experience ___________________________

Evidence of training or competence in hypnosis You may list workshops you are enrolling in at the next annual SCEH conference or titles of attached, peer reviewed publication(s) in hypnosis. (Attach additional page if necessary).

<table>
<thead>
<tr>
<th>Institution/Organization</th>
<th>Dates</th>
<th>Total Hours</th>
<th>Instructors</th>
<th>Nature of Training</th>
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</table>

Title(s) of attached publications in hypnosis ___________________________

Number of years practicing or researching hypnotic techniques __________

Name, title and affiliation of two (2) sponsors. Please request that your sponsors send recommendation forms directly to the SCEH Central Office.

Sponsor #1: ___________________________________________________________________________

Sponsor #2: ___________________________________________________________________________

Signature of Applicant ___________________________ Date ___________________________

Your application will be processed when all required documents are received:

□ Completed Application Form □ 2 Sponsoring Letters □ Curriculum Vitae

□ $150.00 - Payment (type – include relevant information: VISA/MC/Discover #, date of expiration, name on card, check)

________________________________________________________________________

3 digit code:____

Society for Clinical & Experimental Hypnosis

PO Box 252 Southborough, MA 01772

(508) 598-5553 Fax: (866) 397-1839

email: info@sceh.us www.sceh.us
Professional Reference for Clinical Membership

Date: __________________________  Applicant’s Name: ____________________________________________________________________

Thank you for agreeing to sponsor this applicant. The Society for Clinical and Experimental Hypnosis (SCEH) is an international organization of Dentists, Marriage and Family Therapists, Nurses, Physicians, Psychologists and Social Workers that was founded in 1949. Its members have an academic, research and clinical interest in hypnosis and work collaboratively to expand what is known about the nature of hypnosis and the appropriate applications of this technique in health care. The Membership Committee of the Society for Clinical and Experimental Hypnosis will rely heavily on your professional opinion of this candidate in making a decision about membership. If you wish more information about SCEH you might consult our web page listed above.

Referee’s Name: ___________________________  Referee’s Position: __________________________________________________________

Referee’s Professional Membership(s) (list organizations): ________________________________________________________________

How long have you known the applicant? __________________________

What is your relationship to the applicant? __________________________

In what capacity (e.g., supervisor, colleague) are you familiar with the applicant’s professional work? __________________________

Please rate the applicant on the following criteria:  

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<th>Criteria</th>
<th>Excellent</th>
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<th>Poor</th>
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<td>Judgment</td>
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<tr>
<td>Rapport with colleagues</td>
<td>X</td>
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Rapport with patients/research subjects  X  X  X  X  X
Ability to communicate with others  X  X  X  X  X
Academic contributions  X  X  X  X  X

Are you aware of any legal, ethical, medical or personal violations, experiences or attributes involving this applicant that might present a potential danger to patients, research subjects, colleagues or might limit his/her professional work?  X  Yes  X  No  If yes, please explain:
________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________

I recommend this applicant: (please circle one)

Highly Moderately With Reservation Not at all

Comments (if any):
________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________

_____________________________________________________  __________________________________
Signature Date

Thank you for your help with this application. Please return this form to:

Society for Clinical & Experimental Hypnosis
PO Box 252 Southborough, MA 01772
(508) 598-5553  Fax: (866) 397-1839
email: info@sceh.us
www.sceh.us
Date: __________________________  Applicant’s Name: ____________________________________________________________________

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| X | Yes | X | No | If yes, please explain: |

________________________________________________________________________________________________________________________________
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________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________

I recommend this applicant: (please circle one)  

Highly  
Moderately  
With Reservation  
Not at all  

Comments (if any):
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