INTERNATIONAL MEDICAL AND DENTAL HYPNOTHERAPY ASSOCIATION®

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IMDHA Specialty Certification

☐ I am a current **ACTIVE** member of the IMDHA *($50 USD specialty certification fee)*

IMDHA Membership Registration ID # (**required**) **:** _____

Applicant Name *(as it is listed by the Association)* **:** _____

Last Name (*Fam/Sur*) **:** _____ **First Name** (*Given*) **:** _____ **Middle :** _____

Street Address : _____ **Apt/Suite # :** _____

City : _____ **State/Province :** _____ **Postal Code :** _____

Country : _____ **Phone :** _____ **Fax :** _____

Email : _____ **Website :** _____

Applicant Signature : _____ **Date :** _____

Examiner Statement

I hereby certify that the above named applicant has met all of the presented requirements for this Specialty Certification, completing _____ hours of training, and recommend that he/she be granted this certification through the International Medical and Dental Hypnotherapy Association®.

Certification Name : _____

Examiner Name : _____

Registration # : _____ **Phone :** _____

Email : _____ **Website :** _____

Examiner Signature : _____ **Exam Date :** _____

Payment Information

Enter payment details below **OR** securely pay online here →

Check /MO # : _____ **Credit Card Number :** _____ **Exp :** ____/____ **CVV# :** _____

*(Check **must** be drawn from US bank)* *(Visa, MasterCard, Discover, American Express accepted)*

Authorized Signature : _____ **Date :** _____