APPLICATION FOR LICENSURE AND/OR EXAMINATION

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

The following materials are required to make Application for Licensure and/or Examination in Illinois:

1. Four page APPLICATION FOR LICENSURE and/or EXAMINATION.
2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.
5. If the name shown on your supporting documents is different from that shown on your application, you must submit PROOF OF LEGAL NAME change - copy of marriage license, divorce decree, affidavit or court order.

Carefully follow all steps outlined on the INSTRUCTION SHEET. In addition, note the following:

RECEIVED CASH SECTION APR 22 2022 IDFPR Division of Professional Regulation

A. Type or print legibly with black ink only.

B. **FEES ARE NOT REFUNDABLE.**

C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/1-60 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

A. **Check the box indicating the appropriate information regarding your application.** ☐ **Military** ☐ **Military Spouse** ☐ **Not Military** ☐ **Decline to Answer**
Military service member is defined as: "Service member means any person who, at the time of application under this Section, is an active duty member of the United States Armed Forces or any reserve component of the United States Armed Forces, the Coast Guard, or the National Guard of any state, commonwealth, or territory of the United States or the District of Columbia or whose active duty service concluded within the preceding 2 years before application." The following will be considered proof of you or your spouse's active military status: DD214, Letter of Service signed by Unit Commanding Officer, or Proof of Service document from the Servicemember's electronic personnel portal. Proof for Spouses: Military Permanent Change of Station Orders with the spouse identified by name; Official Notification of Change of Assignment with your marriage license, a certified DD1172 verifying marital status, or a letter signed by the commanding officer verifying change of assignment and the name of the military spouse.

B. SEE **REFERENCE SHEET, CHART I, OR INSTRUCTIONS** PRIOR TO COMPLETING ITEMS 1 THROUGH 4

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Physician	0 3 6	RESTORATION	$593.00

C. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- ☐ This is the first time I have made application for this profession in Illinois.
- ☐ I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.
- ☑ Other: Restoration
- ☐ My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.
- ☐ I have previously made application for this profession in Illinois. However, I am now applying under new statutory language.

PART II: Applicant Identifying Information--You must notify the Department of Financial and Professional Regulation - Division of Professional Regulation and/or Continental Testing Service in writing, of any address changes after you file this application in order to receive any further information.

1. NAME LAST	FIRST	MIDDLE	2. TITLE (e.g., M.D., D.D.S., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
Chastine	Cheryl	Ann	M.D.	[redacted]

4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY
[redacted]

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY
1428 N Farwell Ave Milwaukee WI 53202 Milwaukee

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)
—

7. MOTHER'S MAIDEN NAME
[redacted]

8. PLACE OF BIRTH CITY STATE/COUNTRY
[redacted]

9. DATE OF BIRTH
[redacted]
Month Day Year

10. AGE 40 ☑ Female ☐ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED
Work: (414) 278-0424 (Area Code)
Home: [redacted] (Area Code)
Fax: (414) 273-1659 (Area Code)
Fax: (____) ____-____ (Area Code)

12. **REQUIRED** E-MAIL ADDRESS
[redacted]

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.com.

NAME (Last, First, MI):

SS#:

Profession:

PART III: Education Information

1. PRELIMINARY EDUCATION (Elementary and High School or G.E.D. Circle number of years completed)

1 2 3 4 5 6 7 8 9 10 11 (12) Graduated High School? ☑ Yes ☐ No Received OR G.E.D.? ☐ Yes ☐ No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION
duPont Manual Magnet High School	Louisville KY	05/[redacted] Month

5. COLLEGE OR UNIVERSITY (Circle number of years completed)

1 2 3 4 5 6 (7) 8 Graduated? ☑ Yes ☐ No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM	DATES OF ATTENDANCE TO	TYPE OF DEGREE EARNED
University of Louisville	Louisville, KY	Month/Year 1/97	Month/Year 5/98	—
Vanderbilt University	Nashville, TN	8/98	5/01	—
University of Kentucky	Lexington, KY	8/01	5/05	[redacted]
University of Kentucky College of Medicine	Lexington, KY	8/05	5/09	

7. SPECIALIZED TRAINING (Residency, Professional Training, Vocational Training, Practical or Clinical Training)

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM	DATES OF ATTENDANCE TO	Did You Complete Training?
West Suburban Family Medicine Residency Program	Oak Park IL	Month/Year 6/2009	Month/Year 6/2012	☑ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI):

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure Illinois	~~Physician~~ CRC	036.128802	2012	Lapsed
State of Current Licensure where you most recently have been practicing. Wisconsin	Physician	64087-20	2015	Active
Other States of Licensure				
Kansas	Physician	0436207	2013	Lapsed
Oklahoma	Physician	30440	2014	Lapsed

(If additional space is needed, attach a separate sheet.)

SS#:

PART V: Record of Examination

If you have ever taken a licensure examination in Illinois or any other state for the profession for which you are now making application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS (Passed, Failed, Absent)

(If additional space is needed, attach a separate sheet.)

Profession:

NAME (Last, First, MI):

PART VI: Personal History Information *(This part must be completed by all applicants)*

	YES	NO
1. Have you been convicted of or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges. *If yes, attach a personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.*		
2. Have you been convicted of a felony? *In general, a felony conviction by itself does not usually result in denial of licensure.*		
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? *If yes, attach a copy of the certificate.*		
4. Do you now have any disease or condition that presently limits your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		

PART VII: Examination Coding Information *(This part is for examination applicants only)*

Refer to the REFERENCE SHEET enclosed with this application package and complete the following:

a) CHART II - Select examination(s) you desire and enter Test Codes

b) CHART III - Select the examination site you desire and enter Test Center Code:

c) CHART IV - Find your School of Graduation and enter school code:

d) Record the number of times you have taken this exam in Illinois or any other state:

SS#:

PART VIII: Child Support and Tax Information (Every applicant is required by law to respond to the following questions)

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

   Are you more than 30 days delinquent in complying with a child support order?
   (NOTE: If you are not subject to a child support order, answer "no.")

2. In accordance with 20 ILCS 2105-15(g), "The Department shall deny any license application or renewal authorized under any licensing Act administered by the Department to any person who has failed to file a return, or to pay the tax, penalty, or interest shown in a filed return, or to pay any final assessment of tax, penalty, or interest, as required by any tax Act administered by the Illinois Department of Revenue, until such time as the requirement of any such tax Act is satisfied."

   Are you delinquent in the filing of state taxes?

Profession:

PART IX: Certifying Statement

Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

Signature of Applicant

4/19/2022
Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.	**ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION PERSONAL HISTORY INFORMATION**	SUPPORTING DOCUMENT **PH**

NAME LAST	FIRST	MIDDLE	SOCIAL SECURITY NUMBER
Chastine	Cheryl	Ann	[redacted]

In order for your application to be evaluated, you must respond to each of the following questions:	YES	NO
1. Have you ever been disciplined (including but not limited to restricted, suspended, or terminated) by any hospital or health care entity? If yes, attach a separate sheet with complete and accurate explanation.		✓
2. Have you ever resigned in lieu of discipline or while under investigation that could lead to any restriction, suspension, or termination by any hospital or health care entity? *If yes, attach a separate sheet with complete and accurate explanation.*		✓
3. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges involuntarily reduced, limited, placed on probation, relinquished, denied, revoked or suspended? You must answer yes if any of these actions are currently pending or if you have withdrawn or failed to proceed with an application for privileges/memberships. *If yes, attach a separate sheet with complete and accurate explanation AND request the hospital or health care facility to submit a report directly to the Department regarding the action.*		✓
4. Has your provider status ever been restricted, suspended or terminated by any insurance carrier, including but not limited to Medicare, Medicaid, Tricare or any private carrier? If yes, attach a separate sheet with complete and accurate explanation.		✓
5. Have you ever voluntarily surrendered a license to practice medicine in any state, country, or U.S. federal jurisdiction? This does not include allowing your license to expire solely due to non-payment of the renewal fee. *If yes, attach a separate sheet with complete and accurate explanation AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Department.*		✓
6. Have you ever withdrawn an application for a license to practice medicine or any temporary/resident license in any other state, country, or U.S. federal jurisdiction? *If yes, attach a separate sheet with complete and accurate explanation AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Department.*		✓
7. Have you ever been admonished, reprimanded, censured and/or disciplined in any way by any professional or medical society or association or committee thereof, or by any non-licensing governmental agency including but not limited to any governmental assistance agency? (Disciplinary actions include, but are not limited to, any allegations currently pending.) Disclose any stipulation to informal disposition in response to this question. *If yes, attach a separate sheet with a complete and accurate explanation and request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Department.*		✓

Certification Statement

Under penalties of perjury, I declare that I have examined this Form and all supporting documents and/or information submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

[redacted] 4/19/22

Signature of Applicant — Date

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HEALTH CARE WORKERS CHARGED WITH *OR* CONVICTED OF CRIMINAL ACTS

SUPPORTING DOCUMENT

CCA

1. NAME LAST FIRST MIDDLE
Chastine Cheryl Ann

3. PROFESSIONAL LICENSE NUMBER (if any)
036-128802

2. ADDRESS STREET CITY STATE ZIP CODE
[redacted]

4. SOCIAL SECURITY NUMBER
[redacted]

Pursuant to 20ILCS 2105-165(a), the Department requires the following professionals to disclose information regarding convictions pertaining to certain offenses. **Please check applicable profession.**

- ☐ Acupuncturists
- ☐ Advanced Practice Nurses
- ☐ Athletic Trainers
- ☐ Audiologists
- ☐ Clinical Psychologists
- ☐ Clinical Social Workers
- ☐ Dental Hygienists
- ☐ Dentists
- ☐ Genetic Counselors
- ☐ Licensed Clinical Professional Counselors
- ☐ Licensed Practical Nurses
- ☐ Licensed Social Workers
- ☐ Marriage and Family Therapists
- ☐ Medication Aide
- ☐ Naprapaths
- ☐ Nursing Home Administrators
- ☐ Occupational Therapists
- ☐ Occupational Therapy Assistants
- ☐ Optometrists
- ☐ Orthotists
- ☐ Pedorthists
- ☐ Perfusionists
- ☐ Pharmacists
- ☐ Physical Therapists
- ☐ Physical Therapy Assistants
- ☑ Physicians, including Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.), and Chiropractic Physicians (D.C.)
- ☐ Physician Assistants
- ☐ Podiatrists
- ☐ Professional Counselors
- ☐ Prosthetists
- ☐ Registered Nurses
- ☐ Registered Surgical Assistants
- ☐ Registered Surgical Technologists
- ☐ Respiratory Care Practitioners
- ☐ Speech Pathologists

Any other license issued by the Department under the Acts listed in this Section and the Controlled Substances Act [740 ILCS 40], except for pharmacy technicians, issued to a person subject to the Code and this Part.

In order for your application to be evaluated, you must respond to each of the following questions:

1) Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? *
2) Are you currently charged with or have you been convicted of a criminal battery against any patient *in the course of patient care or treatment*, including any offense based on sexual conduct or sexual penetration?
3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? *
4) Are you currently charged with or have you been convicted of a forcible felony? *

[redacted]

*If **YES** to any of the above, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*

Certification Statement

Under penalties of perjury, I declare that I have examined this Form and all supporting documents and/or information submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

[redacted] 4/19/2022

Signature of Applicant Email Date

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Illinois Division of Professional Regulation	As of Date:6/3/2022

PRACTITIONER INFORMATION

Name:	Chastine, Cheryl Ann
DOB:	[redacted]
Medical School:	University of Kentucky College of Medicine Lexington, Kentucky, UNITED STATES
Year of Grad:	2009
Degree Type:	MD
NPI:	[redacted]

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

NATIONAL PROVIDER IDENTIFIER (NPI)

NPI	NPI Type	Deactivation Date	Reactivation Date	Last Reported
[redacted]	Individual			06/04/2018

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PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: Illinois Division of Professional Regulation As of Date:6/3/2022

Practitioner Name: Chastine, Cheryl Ann

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
ILLINOIS	125056559	06/03/2009	06/30/2012	05/27/2022
		FSMB License Status: Canceled		
ILLINOIS	036128802	08/17/2011	07/31/2017	05/27/2022
		FSMB License Status: Inactive		
KANSAS	04-36207	01/17/2013	07/31/2016	06/01/2022
		FSMB License Status: Canceled		
OKLAHOMA	30440	05/12/2014	05/01/2015	06/03/2022
		FSMB License Status: Inactive		
WISCONSIN	64087-20	05/15/2015	10/31/2023	06/01/2022
		FSMB License Status: Active		

ACTIVE US DRUG ENFORCEMENT ADMINISTRATION (DEA)

DEA Number	Schedule	Address	Expiration Date	Last Reported
[redacted]	22N 33N 4 5	[redacted]	08/31/2024	01/05/2022

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PDC PHYSICIAN DATA CENTER

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PRACTITIONER PROFILE

Prepared for: Illinois Division of Professional Regulation As of Date:6/3/2022

Practitioner Name: Chastine, Cheryl Ann

ABMS® CERTIFICATION HISTORY

Certifying Board: American Board of Family Medicine
Certificate: Family Medicine
Certification Type: General
Certification Status: Certified
Participating in MOC: Yes

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	MOC	07/01/2012		07/15/2022	Initial	05/26/2022

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AOA® CERTIFICATION HISTORY

No AOA Certifications found.

PLEASE NOTE: For more information regarding the above data, please contact the reporting board or reporting agency. The information contained in this report was supplied by the respective state medical boards and other reporting agencies. The Federation makes no representations or warranties, either express or implied, as to the accuracy, completeness or timeliness of such information and assumes no responsibility for any errors or omissions contained therein. Additionally, the information provided in this profile may not be distributed, modified or reproduced in whole or in part without the prior written consent of the Federation of State Medical Boards.

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RECEIVED
MAY 25 2022
IDFPR - MEDICAL UNIT

RESTORATION

RECEIVED
CASH SECTION
APR 22 2022
Div. of Professional Regulation

SUPPORTING DOCUMENT
RS

APPLICANT: Complete this form, and return it with your Application for Licensure/Examination. If additional space is required for recording of information, use the reverse side of this form.

1. NAME — LAST: Chastine — FIRST: Cheryl — MIDDLE: Ann

2. DATE OF BIRTH: [redacted] (Month Day Year)

3. SOCIAL SECURITY NUMBER: [redacted]

4. ADDRESS STREET, CITY, STATE, ZIP CODE: [redacted]

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
Physician (Profession Name) — 036 (Profession Code)

6. MAIDEN OR GIVEN SURNAME: —

7. NAME AS IT APPEARS ON EXPIRED/INACTIVE LICENSE: —

8. ISSUANCE DATE OF EXPIRED OR INACTIVE LICENSE: 2012

9. DATE EXPIRED OR PLACED INACTIVE: 2017

10. EXPIRED OR INACTIVE LICENSE NUMBER: 036.128802

OFFICIAL USE ONLY
License No.: 036.128802 Fees: $ 543.00
Issuance Date: 02/27/2021 On CRT: ■Yes □No

11. STATE WHY YOU FAILED TO RENEW YOUR LICENSE.
I was working full time in Wisconsin and had no active plans to work in Illinois.

12. EXPLAIN WHY YOU WANT YOUR LICENSE RESTORED AT THIS TIME.
With the likely reversal of Roe v. Wade, I likely need to relocate my practice to Illinois. This also allows me to do prn contract work and volunteer in Illinois.

13. LIST SPECIFIC EDUCATIONAL ACTIVITIES, I.E., COURSES, CONTINUING EDUCATION CLASSES, WORKSHOPS, READING, ETC., DURING THE PAST FIVE YEARS THAT UPDATED YOUR PROFESSIONAL/OCCUPATIONAL KNOWLEDGE. National Abortion Federation annual conferences; Amer. Board of Family Med. recertification courses; opioid CME; UpToDate self directed research

14. LIST THE STATE(S) AND DATES WHERE YOU HAVE BEEN PRACTICING SINCE YOUR ILLINOIS LICENSE EXPIRED OR WAS PLACED ON INACTIVE STATUS. INCLUDE A BRIEF DESCRIPTION OF DUTIES PERFORMED.

STATE	NAME OF BUSINESS/INSTITUTION	DATES From (Mo/Yr)	DATES To (Mo/Yr)	DESCRIPTION OF DUTIES
WI	Affiliated Medical Services	5/15	present	Contract physician providing pregnancy termination services; medical direct-

I do hereby declare that the information contained herein is true and correct.

4/19/2022 (Date) — [redacted] (Signature)

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. *My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.*

IL486-1081 07/04 L&T

Cheryl Chastine, MD
[redacted]

TO: IDFPR
fpr.medicalunit@illinois.gov

To Whom It May Concern:

I hereby swear and affirm that I have been self-employed in private practice at Affiliated Medical Services in Milwaukee, Wisconsin, from May 2015 to the present, inclusive of three years preceding this application for restoration of my license.

[redacted]
Cheryl Chastine, MD
036.128802
July 12, 2022

ALL-PURPOSE ACKNOWLEDGMENT

State/Commonwealth of VIRGINIA)
)
☐ City ☑ County of Henrico)

On 07/12/2022 (Date) before me, Dequan Winborne (Notary Name),

personally appeared Cheryl Ann Chastine
(Name(s) of Signer(s))

☐ personally known to me – OR –

☐ proved to me on the basis of the oath of _____ – OR –
(Name of Credible Witness)

☑ proved to me on the basis of satisfactory evidence: driver_license
(Type of ID Presented)

to be the individual(s) whose name(s) is (are) subscribed to the within instrument, and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies) and by proper authority, and that by his/her/their signature(s) on the instrument, the individual(s), or the person(s) or entity upon behalf of which the individual(s) acted, executed the instrument for the purposes and consideration therein stated.

WITNESS my hand and official seal.

Electronic Notary Public

Dequan Winborne

REGISTRATION NUMBER
7940580
COMMISSION EXPIRES
June 30, 2025

Notary Public Signature: [redacted]

Notary Name: Dequan Winborne

Notary Commission Number: 7940580

Notary Commission Expires: 06/30/2025

Notarized online using audio-video communication

DESCRIPTION OF ATTACHED DOCUMENT

Title or Type of Document: Affidavit

Document Date: 07/12/2022 Number of Pages (w/ certificate): 2

Signer(s) Other Than Named Above: N/A

Capacity(ies) Claimed by Signer(s)

Signer's Name: Cheryl Ann Chastine

☐ Corporate Officer Title: N/A
☐ Partner – ☐ Limited ☐ General
☑ Individual ☐ Attorney in Fact
☐ Trustee ☐ Guardian of Conservator
☐ Other: N/A

Signer Is Representing: Herself

Capacity(ies) Claimed by Signer(s)

Signer's Name: N/A

☐ Corporate Officer Title: N/A
☐ Partner – ☐ Limited ☐ General
☐ Individual ☐ Attorney in Fact
☐ Trustee ☐ Guardian of Conservator
☐ Other: N/A

Signer Is Representing: N/A