The American Board of Family Medicine
Certificate of Successful Completion

Dr. Cheryl Chastine

COVID-19 Self-Directed Clinical Pilot

June 16, 2020 **20 Credits**

This Performance Improvement activity, COVID-19 Self-Directed Clinical Pilot, has been reviewed and is acceptable for up to 20.00 Prescribed credit(s) by the American Academy of Family Physicians. Term of approval begins 04/01/2020. Term of approval is for two years from this date. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn twenty (20) Performance Improvement points in the American Board of Family Medicine (ABFM) Family Medicine Certification program.

1648 McGrathiana Parkway Suite 550, Lexington KY. 40511-1247
Phone: 877-223-7437 | Email: help@theabfm.org

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Behavioral Health Care Knowledge Self-Assessment

January 18, 2022 **8 Credits**

The AAFP has reviewed Behavioral Health Care Knowledge Self-Assessment and deemed it acceptable for up to 8.00 Enduring Materials, Self-Study AAFP Prescribed credit. Term of Approval is from01/01/2022 to 12/31/2022. Physicians should claim only the credit to commensurate with the extent of their participation in the activity.

AMA/AAFP Equivalency: AAFP Prescribed credit is accepted by the American Medical Association as equivalent to AMA PRA Category 1 credit(s)™ toward the AMA Physician's Recognition Award. When applying for the AMA PRA, Prescribed credit earned must be reported as Prescribed, not as Category 1.

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Asthma Knowledge Self-Assessment

February 14, 2022 **8 Credits**

The AAFP has reviewed Asthma Knowledge Self-Assessment and deemed it acceptable for up to 8.00 Enduring Materials, Self-Study AAFP Prescribed credit. Term of Approval is from 01/01/2022 to 12/31/2022 Physicians should claim only the credit to commensurate with the extent of their participation in the activity.

AMA/AAFP Equivalency: AAFP Prescribed credit is accepted by the American Medical Association as equivalent to AMA PRA Category 1 credit(s)™ toward the AMA Physician's Recognition Award. When applying for the AMA PRA, Prescribed credit earned must be reported as Prescribed, not as Category 1.

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PCSS Providers Clinical Support System

American Academy of Addiction Psychiatry
Translating Science. Transforming Lives.

American Academy of Addiction Psychiatry

certifies that:

Cheryl A Chastine

has participated in the Enduring Material Activity titled:

Module 6: Understanding and Assessing Opioid Use Disorder in Patients with Chronic Pain

Completion Date: April 01, 2022

Credit(s) Awarded: 1.00 CME

In support of improving patient care, American Academy of Addiction Psychiatry is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

American Academy of Addiction Psychiatry designates this enduring material for a maximum of 1 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

[redacted]

Bethany Banner, MPH, CHCP
Director of Professional Development

Certificate of Completion

NetCE certifies that
Cheryl A. Chastine 036128802
has participated in the enduring material titled
#97280 Pain Management Pearls: Opioids and Culture
on March 15, 2021
and is awarded 2
AMA PRA Category 1 Credit(s) ™.

JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION

In support of improving patient care, NetCE is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

Florida CE Broker Provider #50-2405, Board of Medicine.

This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency.

[redacted]
Sarah Campbell
Director of Development and Academic Affairs

NetCE
A TRC Healthcare Company

PO BOX 997571 • SACRAMENTO, CALIFORNIA 95899-7571 • (800) 232-4CEU

Certificate of Completion

NetCE certifies that
Cheryl A. Chastine 64087-20
has participated in the enduring material titled
#97280 Pain Management Pearls: Opioids and Culture
on March 15, 2021
and is awarded 2
AMA PRA Category 1 Credit(s)™.

JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION

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[redacted]
Sarah Campbell
Director of Development and Academic Affairs

NetCE
A TRC Healthcare Company

Certificate of Completion

NetCE certifies that
Cheryl A. Chastine 036128802
has participated in the enduring material titled
#97080 Sexual Harassment
Prevention: The Illinois Requirement
on March 15, 2021
and is awarded 1
AMA PRA Category 1 Credit(s)™.

JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION

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Florida CE Broker Provider #50-2405, Board of Medicine.

This course is designed to fulfill the Illinois requirement for 1 hour of continuing education in the area of sexual harassment prevention. This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency.

[redacted]
Sarah Campbell
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[redacted]
Sarah Campbell
Director of Development and Academic Affairs

NetCE
A TRC Healthcare Company

RECEIVED
MAY 25 2022
DEPT. MEDICAL UNIT

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

FOR OFFICIAL USE ONLY

IMPORTANT NOTICE: Completion of this form is required by 720 ILCS 570/301 et. seq. (Illinois Compiled Statutes). Disclosure of information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application.

Disclosure of your U.S. social security number, if you have one, is ***mandatory***, in accordance with 5 Illinois Compiled Statutes 100/10-65 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

1. PROFESSION NAME	2. PROFESSION CODE - Check applicable box	3. LICENSURE METHOD	4. FEE
Controlled Substances	☐319 Dentist ☐346 Optometrist ☐316 Podiatrist ☐390 Veterinarian ☑336 Physician	RESTORATION	$15

PART II: Applicant Identifying Information

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

4. PERMANENT MAILING ADDRESS CITY STATE/COUNTRY ZIP CODE COUNTY

[redacted]

5. NAME OF BUSINESS AND LOCATION (STREET / CITY / STATE / ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES REGISTRATION IS TO BE ISSUED

not yet determined

6. EMAIL ADDRESS (REQUIRED) [redacted]

7. If you will ***not*** be storing or dispensing controlled substances, check the box below. Your license will be issued to your permanent mailing address.

☐ I will ***not*** be storing or dispensing controlled substances, including samples.

8. MAIDEN OR GIVEN SURNAME, OR ANY NAME(S)

9. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY

Work (~~312~~) 414-278-0424 FAX (414) 273-1659
Area Code Area Code

Hom [redacted] FAX ( ) _____
Area Code Area Code

PART III: Drug Schedule

Circle the schedules for which you are applying:

II III IV V

PART IV: Professional Activity

Practitioner--Check and complete one of the following:

		Professional License Number
☐	Dentist	019 - _____
☐	Optometrist	046 - _____
☑	Physician	036 - 128802
☐	Podiatrist	016 - _____
☐	Veterinarian	090 - _____

PART V: 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.		
7. Has your authority to prescribe or dispense controlled substances granted by either the U.S. Drug Enforcement Administration (DEA) or any state/territory of the U.S. (including Illinois) ever been voluntarily or involuntarily reduced, limited, placed on probation, relinquished, denied, revoked or suspended or otherwise disciplined? You must answer yes if any of the above actions are currently pending or if you have withdrawn or failed to proceed with an application for any controlled substances license. If yes, attach a separate sheet with complete and accurate explanation and certified documentation from the appropriate entity regarding the action.		

PART VI: Child Support and/or Student Loan 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 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)

   Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State?

PART VII: Certifying Statement

I hereby apply for an Illinois Controlled Substances Registration in accordance with the Illinois Controlled Substances Act. I certify that I have answered all questions on this application to the best of my knowledge.

4/19/2022
Date of Application

Signature of Applicant

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.

Application must be completed in its entirety.
If not completed, it will be returned to the address noted on front of application.

NAME (Last, First, MI):

SS#:

Profession:

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

Request for Reinstatement of Illinois License

PLEASE PRINT

License No: 036.128802 SSN (Last four only): 4132 Date of Birth: [redacted]

First Name: Cheryl Last Name: Chastine

Address: [redacted]

City: [redacted] State: [redacted] Zip: [redacted]

Phone Number: [redacted] Email Address: [redacted]

☑ **CHECK HERE IF NAME OR ADDRESS CHANGE.** A name change must be accompanied by documentary proof. Proof must be a certified copy with an official stamp or seal and be one of the following: Marriage Certificate, Divorce Decree or Court Order.

CHECK THE APPROPRIATE ANSWER BELOW:

Are you more than 30 days delinquent in complying with a child support order? **NOTE:** If you are not subject to a child [redacted] "No".

☐ **CHECK THE BOX IF YOU ARE A MILITARY SERVICE MEMBER AND /OR SPOUSE.** (P.A. 101-0240) "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."

I understand if I provide false/fraudulent information I could lose my license, be fined and/or have other penalties assessed. I also understand the FEES ARE NOT REFUNDABLE. Therefore, I declare that I have examined this form and, to the best of my knowledge, all statements are true, correct and complete.

Signature: [redacted] Date: 4/19/2022

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, but in no event shall such reduction be made in an amount greater than $50.

INCOMPLETE REINSTATEMENT: Incomplete forms will be returned and result in a substantial delay in the reissuance of your license. Please assure your reinstatement includes the following:

- Reinstatement form must be completed in full, include the required fee and a signature.
- Fee must be a check or money order, payable to the Illinois Department of Financial and Professional Regulation. Do not mail cash.
- Verify the appropriate fee amount.
- Include any necessary and required supporting documentation such as: Proof of CE and completion of the **CCA Form** (if applicable). Verification of the requirements are available on our website: **www.idfpr.com**

SEND ALL REQUIRED INFORMATION AND PAYMENT TO:

ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
DIVISION OF PROFESSIONAL REGULATION
POST OFFICE BOX 7450
SPRINGFIELD, IL 62791-7450

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.

VERIFICATION OF EMPLOYMENT / EXPERIENCE

SUPPORTING DOCUMENT
VE

APPLICANT: ***Complete the application section of this form, then forward it to your employer. Upon receipt of the completed form from the employer, include it with your Application for Licensure/Examination. You are authorized to photocopy this form as necessary.***

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. JOB TITLE OR POSITION APPLICANT HELD: Medical Director
8. DATES OF EMPLOYMENT From 05./29./2015. (Month Day Year) To present (Month Day Year)
9. SUPERVISOR NAME: self

EMPLOYER: ***Complete the remainder of this form. Return the completed form to the applicant in a sealed envelope.***

PART I - EMPLOYMENT INFORMATION

A. EMPLOYER NAME: self
B. BUSINESS / INSTITUTION NAME: Affiliated Medical Services
C. EMPLOYER REGISTRATION/LICENSE NUMBER:
D. STATE OF EMPLOYER REGISTRATION/LICENSE:
E. BUSINESS ADDRESS STREET CITY STATE ZIP CODE: 1428 N Farwell Ave, Milwaukee, WI 53202
F. BUSINESS REGISTRATION/LICENSE NUMBER (If Applicable):
G. STATE OF BUSINESS REGISTRATION/LICENSE:
H. BUSINESS TELEPHONE NUMBER Area Code (414.) 278.-0424

PART II - APPLICANT EMPLOYMENT INFORMATION

A. NUMBER OF HOURS WORKED PER WEEK: 28.
B. TYPE OF EMPLOYMENT: [X] Full-time [ ] Part-time
C. DATES OF EMPLOYMENT From 05./29./2015 (Month Day Year) To present (Month Day Year)
D. RECORD APPLICANT'S POSITION TITLE(S): Medical Director
E. GIVE BRIEF DESCRIPTION OF DUTIES PERFORMED BY THE APPLICANT: medical and surgical termination of pregnancy, ultrasound, management of medical pro

I do hereby declare that this information is true and correct.

[redacted] (Signature)

06/23/2022 (Date)

Medical Director (Title)

IL486-1348 04/06 (L&T)