# APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

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:

URE AND/OR

Lic#:
CHASTINE, CHERYL ANN
125 Cred #2901438 04/22/2009
By:NON-EXAM
SSN [redacted]

step by step

etailed coding

id/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:

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 100/10-65 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

A. 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 |
|---|---|---|---|
| **TEMPORARY PHYSICIAN LICENSURE** | 1 2 5 | **NON-EXAMINATION** | **$ 100.00** |

B. 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: _____
- ☐ 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: **WEST SUBURBAN MEDICAL CENTER 3 ERIE COURT - GME L-700** | CITY STATE/COUNTRY: **OAK PARK IL USA** | ZIP CODE: **60302** | COUNTY: **COOK**

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

7. MOTHER'S MAIDEN NAME: [redacted]

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

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

10. AGE: 27 ☑ Female ☐ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED
Work: ( 708 ) 763 - 2369 (Area Code)
Home: [redacted] (Area Code)
Fax: ( 708 ) 763 - 2162 (Area Code)
Fax: ( ) - (Area Code)

12. PREFERRED e-MAIL ADDRESS(ES) [If available]: [redacted]



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

NAME (Last, First, MI): Chastine, Cheryl A.

SS#: [redacted]

Profession: TEMPORARY PHYSICIAN LICENSURE

## 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 Month / Year |
|---|---|---|
| duPont Manual Magnet High School | Louisville, KY | 05 / [redacted] |

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 (Month/Year) | DATES OF ATTENDANCE TO (Month/Year) | TYPE OF DEGREE EARNED |
|---|---|---|---|---|
| U. of Louisville | Louisville, KY | 01/1997 | 05/1998 | — |
| Vanderbilt U. | Nashville, TN | 08/1998 | 05/2001 | — |
| U. of Kentucky | Lexington, KY | 08/2001 | 05/2005 | [redacted] |
| U. of Kentucky College of Medicine | Lexington, KY | 08/2005 | 05/2009 | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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

| INSTITUTION NAME | LOCATION (City and State or Country) | DATES OF ATTENDANCE FROM (Month/Year) | DATES OF ATTENDANCE TO (Month/Year) | Did You Complete Training? |
|---|---|---|---|---|
| **WEST SUBURBAN MEDICAL CENTER FAMILY MEDICINE RESIDENCY** | **OAK PARK IL** | 07/2009 | 06/2012 | ☐ Yes ☑ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |

NAME (Last, First, MI): Chastine, Cheryl A.

SS#: [redacted]

Profession:

TEMPORARY PHYSICIAN LICENSURE

## 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 | | | | |
| State of Current Licensure where you most recently have been practicing. | | | | |
| Other States of Licensure | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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

## 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) |
|---|---|---|---|
| USMLE Step 1 | Kentucky | 06/2007 | [redacted] |
| USMLE Step 2 - CK | Kentucky | 07/2008 | |
| USMLE Step 2 - CS | Georgia | 09/2008 | |
| | | | |
| | | | |
| | | | |

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

NAME (Last, First, MI): Chastine, Cheryl A.

SS#: [redacted]

Profession: TEMPORARY PHYSICIAN LICENSURE

| PART VI: Personal History Information *(This part must be completed by all applicants)* | YES | NO |
|---|---|---|
| 1. Have you been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, 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.* | [redacted] | |
| 2. Have you been convicted of a felony? | | |
| 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. Have you had or do you now have any disease or condition that interferes with 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, that presently interferes with your ability to practice your profession? *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: ☐☐

**PART VIII: 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.")* [redacted]

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? [redacted]

**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.

[redacted] Signature of Applicant

3/26/09 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 for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

# CERTIFICATE OF ACCEPTANCE FOR SPECIALTY/RESIDENCY PROGRAM

SUPPORTING DOCUMENT

# CA-MED

**NOTE: An applicant shall not commence specialty/residency training before he or the hospital/institution receives written notice of the approval of his application from the Department of Financial and Professional Regulation.**

**APPLICANT: Complete the applicant section of this form, then forward it to the hospital/institution that has accepted you for specialty/residency training, for completion of the remainder of the 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.

TEMPORARY PHYSICIAN LICENSURE 125
Profession Name — Profession Code

6. MAIDEN OR GIVEN SURNAME: Chastine

**ADMINISTRATOR: Complete the remainder of this form and return it to the applicant.**

A. HOSPITAL/INSTITUTION NAME: **WEST SUBURBAN MEDICAL CENTER**

B. BEGINNING DATE: 07 / 01 / 2009 (Month / Day / Year)

C. ENDING DATE: 06 / 30 / 2012 (Month / Day / Year)

D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE: **WEST SUBURBAN MEDICAL CENTER 3 ERIE COURT GME L-700 OAK PARK IL 60302**

E. SPECIALTY / RESIDENCY NAME: **FAMILY MEDICINE RESIDENCY**

F. BUSINESS TELEPHONE NUMBER: Area Code ( 708 ) 763 — 2369

G. YEAR OF POSTGRADUATE TRAINING: **PGY-1**

I do hereby declare that the above named applicant will be accepted for specialty/residency training as indicated above if, subsequent to the evaluation of medical education and/or clinical skills by the Department of Financial and Professional Regulation, the applicant is found to be eligible for licensure.

[redacted]
Signature of Program Director

**Scott Levin, MD**
Print Name of Program Director

**Program Director**
**Family Medicine Residency**
Title

3/25/09
Date

SEAL

IL486-0272 08/04 (MD)

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 ILCS 60/1 et.seq. Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

# CERTIFICATION OF EDUCATION

**(Current Year Graduates of LCME and COCA-Accredited Programs Only)**

SUPPORTING DOCUMENT

# ED - MED

**APPLICANT:** ***Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form.***

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

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

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.

TEMPORARY PHYSICIAN LICENSURE (Profession Name) 125 (Profession Code)

6. MAIDEN OR GIVEN SURNAME: —

I hereby authorize a school official of the institution named above to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service the information requested below.

3/26/09 (Date) [redacted] (Signature)

**SCHOOL OFFICIAL: Complete the bottom portion of this page and RETURN THIS FORM TO THE APPLICANT.**
***DO NOT complete this form more than 30 days prior to the graduation date.***

A. MEDICAL SCHOOL INFORMATION

Name: University of Kentucky College of Medicine
Office of Student Affairs
Address: 138 Leader Avenue
City, State, ZIP: Lexington, KY 40506-9983
Phone: 859 323 2456
Fax: 859 323 2076

B. DATES OF ATTENDANCE

Start: 08 / 01 / 2005 (Month / Day / Year)
End: 05 / 14 / 2009 (Month / Day / Year)
Degree: ✓ MD ____ DO

C. CHECK THE APPROPRIATE STATEMENT

{ } Applicant has graduated on ___ / ___ / ____ (Month / Day / Year)

{ ✓ } Applicant will complete all requirements for the medical degree as of 05 / 14 / 2009 (Month / Day / Year) and will graduate on 05 / 16 / 2009 (Month / Day / Year).

***When this form is certified prior to the actual graduation of the applicant, the school official is responsible for notifying the Department of Financial and Professional Regulation of any failure on the part of the applicant to complete the requirements for graduation.***

I certify that the information recorded herein is true and correct according to the official records of this institution.

[redacted] (Signature of School Official)

SCHOOL SEAL

Beth Hartmann, Registrar
University of Kentucky College of Medicine (Print Name of School Official)

Title

4/17/09 (Date)

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# VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

# VE-PC

1. NAME LAST FIRST MIDDLE

Chastine Cheryl Ann

3. ADDRESS STREET, CITY, STATE, ZIP CODE

[redacted]

4. DATE OF BIRTH

[redacted]

Month Day Year

5. SOCIAL SECURITY NUMBER

[redacted]

2. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:

| | Profession Code |
|---|---|
| ☐ Permanent Physician License | 036 |
| ☑ Temporary Physician Training License | 125 |
| ☐ Chiropractic Physician License | 038 |

6. MAIDEN OR GIVEN SURNAME

Chastine

**Record work history chronologically for the five (5) years preceding the date of application beginning with present employment.**

A. NAME OF BUSINESS / INSTITUTION

Univ. of Kentucky College of Medicine

ADDRESS STREET, CITY, STATE, ZIP CODE

330 Rose St, Lexington, KY 40536

DATE OF EMPLOYMENT/ATTENDANCE

From 07 / 29 / 2005 (Month / Day / Year)

To 05 / 16 / 2009 (Month / Day / Year)

HOURS WORKED PER WEEK

40+

TYPE OF EMPLOYMENT

☑ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

3 years 9 months

JOB TITLE

Medical Student

DESCRIPTION OF DUTIES PERFORMED

B. NAME OF BUSINESS / INSTITUTION

University of Kentucky

ADDRESS STREET, CITY, STATE, ZIP CODE

330 Rose St, Lexington, KY 40536

DATE OF EMPLOYMENT/ATTENDANCE

From 02 / 20 / 2005 (Month / Day / Year)

To 07 / 16 / 2005 (Month / Day / Year)

HOURS WORKED PER WEEK

20

TYPE OF EMPLOYMENT

☐ Full-time ☑ Part-time

TOTAL TIME WORKED (Year/Month)

5 months

JOB TITLE

Laboratory Aide

DESCRIPTION OF DUTIES PERFORMED

cleaned glassware
mixed solutions

IL486-1965 08/06 (MD)

C. NAME OF BUSINESS / INSTITUTION: U. of Kentucky Student Computing Services

JOB TITLE: Consultant

ADDRESS STREET, CITY, STATE, ZIP CODE: B24A W.T. Young Library, Lexington, KY 40506

DESCRIPTION OF DUTIES PERFORMED: Provided support for student users of campus computing labs

DATE OF EMPLOYMENT/ATTENDANCE
From 02/15/2004 (Month/Day/Year)
To 12/19/2004 (Month/Day/Year)

HOURS WORKED PER WEEK: 12

TYPE OF EMPLOYMENT: ☐ Full-time ☑ Part-time

TOTAL TIME WORKED (Year/Month): 10 months

D. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE
From ___ / ___ / _____ (Month/Day/Year)
To ___ / ___ / _____ (Month/Day/Year)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT: ☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

E. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE
From ___ / ___ / _____ (Month/Day/Year)
To ___ / ___ / _____ (Month/Day/Year)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT: ☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

F. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE
From ___ / ___ / _____ (Month/Day/Year)
To ___ / ___ / _____ (Month/Day/Year)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT: ☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

NAME (Last, First, MI): Chastine, Cheryl A

SS#: [redacted]

Profession:

TEMPORARY PHYSICIAN LICENSURE

**STATE OF ILLINOIS**
**DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION**
**DIVISION OF PROFESSIONAL REGULATION**

June 3, 2009

CHERYL ANN CHASTINE MD
WEST SUBURBAN MEDICAL CENTER
DEPT OF GME
3 ERIE COURT STE L70
OAK PARK, IL 60302-2599

The Illinois Temporary Medical License or Permit for the resident listed above has been approved and will be forwarded to your facility as soon as office routine permits. Information regarding all licensees is available instantly on our Web site at www.idfpr.com. Simply click on the Express Access License Look-up icon to verify a license.

**LICENSE DETAILS**

| | |
|---|---|
| LICENSE NUMBER: | 125.056559 |
| PROGRAM START DATE: | 07/01/2009 |
| EXPIRATION DATE: | 06/30/2012 |
| PROGRAM: | Family Medicine |
| TRAINING FACILITY: | WEST SUBURBAN MEDICAL CENTER |

**Utilization of this license is limited to the training program listed above.**

Temporary licenses and permits may not be used for any clinical medical practice which occurs outside of the residency program (i.e. moonlighting).

Temporary licenses and permits are **not** automatically transferred from one program/institution to another. Should the resident transfer to a different residency program within your facility or to a program in another institution, the license or permit must be updated. The resident may not begin a new program until the current temporary license or permit has been returned to the Division and a license or permit has been issued for the new program.

The Medical Practice Act sets forth the appropriate use of temporary licenses and permits. Any violation of the Act may result in disciplinary action by this Department.

Direct Inquiries to the
Technical Assistance Unit

Telephone No.: 217-782-8556
TDD No.: 217-524-6735

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL & PROFESSIONAL REGULATION
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786
www.idfpr.com

Date: 4/28/2009

Initials: DR

License No: 125 Attn: Medical

**YOUR APPLICATION OR REQUEST CANNOT BE PROCESSED DUE TO ERRORS OR DEFICIENCIES. NO FURTHER ACTION CAN BE TAKEN ON YOUR APPLICATION UNTIL SUCH TIME AS ALL DEFICIENCIES HAVE BEEN MET.**

TO:

CHERYL ANN CHASTINE MD
WEST SUBURBAN MEDICAL CENTER
DEPT OF GME
3 ERIE COURT STE L70
OAK PARK, IL 60302-2599

**RETURN THIS FORM AND APPLICATION WITH REMITTANCE, IF APPLICABLE**

**Deficiency Checklist**

ED-MED may be completed and submitted by your medical school with seal affixed not more than 30-days prior to graduation.
OR
Submit official transcript(s) verifying medical education with school seal/signature upon graduation.

RETURN INFORMATION IN THE ENCLOSED ENVELOPE WITH A COPY OF THIS NOTICE.