RECEIVED
NOV 26 2012
KSBHA

Application for Physician Licensure

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name Chastine
First Name Cheryl
Middle Name Ann
Suffix
Maiden Name
M.D. ☑ D.O. ☐

All other names used

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website; therefore, you should consider what your preferred address is for these purposes.

Practice Address
☑ Public Access
☑ Mailing

Street 5101-5107 E Kellogg Dr
City Wichita State/Province KS ZIP Code 67218
Telephone 316-425-3215 Fax 316-425-3451
E-mail address Confidential
Alternate Phone (e.g. pager or cell phone)

Confidential

Home Address
☐ Public Access
☑ Mailing

Street
City Chicago State/Province IL ZIP Code 60622
Telephone Confidential
E-mail address Confidential
Alternate Phone (e.g. pager or cell phone) Confidential

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

Confidential

1981	Louisville	KY	USA
Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

F — Gender

Confidential — Social Security Number

1831325505 — NPI Number

Are you a U.S. Citizen? ☑ Yes ☐ No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI , please go to http://www.cms.hhs.gov/NationalProvIdentStand/.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School (attach additional pages if necessary)

1. School Name: University of Kentucky College of Medicine
   Address:
   City: Lexington — State/Province: KY — ZIP Code: 405
   Country: USA
   Attendance Dates (From – To): August 2005 - May 2009
   Graduation Date: May 2009 — Degree: MD

2. School Name:
   Address:
   City: — State/Province: — ZIP Code:
   Country:
   Attendance Dates (From – To):
   Graduation Date: — Degree:

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

1. Medical School Name _____

Address _____

City _____ State/Province _____ ZIP Code _____

Country _____

Attendance Dates (From – To) _____

Graduation Date _____ Degree _____

2. Medical School Name _____

Address _____

City _____ State/Province _____ ZIP Code _____

Country _____

Attendance Dates (From – To) _____

Graduation Date _____ Degree _____

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. The postgraduate program must forward all documentation directly to this Board.

RECEIVED
NOV 26 2012
KSBHA

6. Postgraduate Training (copy and attach additional pages if necessary)

Complete name and address of hospital where training was conducted (Do Not Abbreviate)

1.Hospital Name West Suburban Medical Center

Hospital Address 1 Erie Ct

City Oak Park

State/Province IL

ZIP Code 60302

Country USA

PGY: (e.g., 1, 2, 3, etc.) ☑ Internship ☑ Residency ☐ Fellowship ☐ Research ☐ Other 1, 2, 3

Accredited by: ☑ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other _____

Department/Specialty: Family Medicine

From: 06 / 2009 To: 06 / 2012 Successfully Completed? Yes ☑ No ☐ In Progress ☐

Month Year Month Year

2.Hospital Name _____

Hospital Address _____

City _____

State/Province _____

ZIP Code _____

Country _____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Accredited by: ☐ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other _____

Department/Specialty: _____

From: / To: / Successfully Completed? Yes ☐ No ☐ In Progress ☐

Month Year Month Year

Applicant Name: Cheryl Chastine Date: 11/20/12

6. Postgraduate Training (continued)

3.Hospital Name_____

Hospital Address_____

City_____

State/Province_____

ZIP Code_____

Country_____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Accredited by: ☐ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other_____

Department/Specialty:_____

From: ___/_____ To: ___/_____ Successfully Completed? Yes☐ No☐ In Progress☐

Month Year Month Year

4.Hospital Name_____

Hospital Address_____

City_____

State/Province_____

ZIP Code_____

Country_____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Accredited by: ☐ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other_____

Department/Specialty:_____

From: ___/_____ To: ___/_____ Successfully Completed? Yes ☐ No ☐ In Progress ☐

Month Year Month Year

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.). If additional space is necessary, please enclose a separate sheet with your application and include all the information below.

Examination		Most Recent Date taken (Month/Year)	Passed (P) or Failed (F)		Number of attempts
			☐ P	☐ F	
State Board Exam	State				
FLEX Pre-1985			☐ P	☐ F	
FLEX Component 1			☐ P	☐ F	
FLEX Component 2			☐ P	☐ F	
LMCC – Single			☐ P	☐ F	
LMCC – Part I			☐ P	☐ F	
LMCC – Part II			☐ P	☐ F	
NBME Part I			☐ P	☐ F	
NBME Part II			☐ P	☐ F	
NBME Part III			☐ P	☐ F	
SPEX			☐ P	☐ F	
NBOME Part I			☐ P	☐ F	
NBOME Part II			☐ P	☐ F	
NBOME Part III			☐ P	☐ F	
COMLEX-USA Level 1			☐ P	☐ F	
COMLEX-USA Level 2, CE			☐ P	☐ F	
COMLEX-USA Level 2, PE			☐ P	☐ F	
COMLEX-USA Level 3			☐ P	☐ F	
COMVEX			☐ P	☐ F	
USMLE Step I		06/2007	☑ P	☐ F	1
USMLE Step II, CS		10/2008	☑ P	☐ F	1
USMLE Step II, CK		06/2008	☑ P	☐ F	1
USMLE Step III		06/2011	☑ P	☐ F	1

Applicant Name: Cheryl Chastine Date: 11/20/12

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG website at www.ecfmg.org.

RECEIVED
NOV 26 2012
KSBHA

8. ECFMG (if applicable)

Certificate Number _____ Issue Date _____ Valid Through Date _____

9. State/Province Professional Licensure whether temporary or permanent: List all states and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license or certification. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states or provinces in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure – MD or DO only – attach additional pages if necessary

1. State/Province IL Type (MD, DO) MD License Number 036.128802 Status active Issue Date 7/2011
2. State/Province _____ Type (MD, DO) _____ License Number _____ Status _____ Issue Date _____
3. State/Province _____ Type (MD, DO) _____ License Number _____ Status _____ Issue Date _____
4. State/Province _____ Type (MD, DO) _____ License Number _____ Status _____ Issue Date _____
5. State/Province _____ Type (MD, DO) _____ License Number _____ Status _____ Issue Date _____
6. State/Province _____ Type (MD, DO) _____ License Number _____ Status _____ Issue Date _____
7. State/Province _____ Type (MD, DO) _____ License Number _____ Status _____ Issue Date _____
8. State/Province _____ Type (MD, DO) _____ License Number _____ Status _____ Issue Date _____
9. State/Province _____ Type (MD, DO) _____ License Number _____ Status _____ Issue Date _____
10. State/Province _____ Type (MD, DO) _____ License Number _____ Status _____ Issue Date _____

Applicant Name: Cheryl Chastine Date: 11/20/12

All Other Health Care Licensure/Certification (e.g., RN, PA, etc.) - attach additional pages if necessary.

1. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
2. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
3. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
4. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
5. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____

10. Chronology of Activities: List ALL activities (medical, non-medical and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities (copy and attach additional pages if necessary)

Dates: From/To	Practice/Employment
1. From: Month: 05 Year: 2009 To: Month: 06 Year: 2009	Practice/Employment Name: Vacation (or list non-working time as indicated above) Practice/Employment Address: 324 Lake St City: Oak Park State/Province: IL ZIP Code: 60302 Country: USA Position and Department: n/a % Clinical: _____ % Administrative: _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other: _____
2. From: Month: 06 Year: 2009 To: Month: 06 Year: 2012	Practice/Employment Name: West Suburban Medical Center (or list non-working time as indicated above) Practice/Employment Address: 1 Erie Ct City: Oak Park State/Province: IL ZIP Code: 60302 Country: USA Position and Department: resident % Clinical: 100 % Administrative: 0 Employment ☑ Staff Privileges ☐ Affiliation ☐ Other: _____

Applicant Name: Cheryl Chastine Date: 11/20/12

Dates: From/To	Practice/Employment
3. From: Month: 07 Year: 2009 To: Month: 08 Year: 2009	Practice/Employment Name vacation (or list non-working time as indicated above) Practice/Employment Address 1644 W Augusta Blvd City Chicago State/Province IL ZIP Code 60622 Country USA Position and Department n/a % Clinical ____ % Administrative ____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other ____
4. From: Month: 08 Year: 2009 To: Month: present Year: ____	Practice/Employment Name McCammon-Chase Total Wellness Center (or list non-working time as indicated above) Practice/Employment Address 917 B S Oak Park Ave City Oak Park State/Province IL ZIP Code 60304 Country USA Position and Department physician % Clinical 100 % Administrative 0 Employment ☑ Staff Privileges ☐ Affiliation ☐ Other ____
5. From: Month: ____ Year: ____ To: Month: ____ Year: ____	Practice/Employment Name ____ (or list non-working time as indicated above) Practice/Employment Address ____ City ____ State/Province ____ ZIP Code ____ Country ____ Position and Department ____ % Clinical ____ % Administrative ____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other ____
6. From: Month: ____ Year: ____ To: Month: ____ Year: ____	Practice/Employment Name ____ (or list non-working time as indicated above) Practice/Employment Address ____ City ____ State/Province ____ ZIP Code ____ Country ____ Position and Department ____ % Clinical ____ % Administrative ____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other ____

RECEIVED
NOV 26 2012
KSBHA

Applicant Name: Cheryl Chestine Date: 11/20/12

11. Malpractice Liability Claims Information (copy this form to report multiple claims)

Name of patient involved: none

In which state did the action take place? _____ Case number (if applicable) _____

Which court? _____
(If private compromise or settled before initiation of civil action, state here)

Current status of claim: _____

☐ Open (pending) ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out)
☐ Other _____

Amount of judgment or settlement $ _____ Amount paid on your behalf $ _____

Month and year of event precipitating claim: _____

Month and year of lawsuit: _____

Insurance carrier at time: _____

What is/or was your status? ☐ Primary defendant ☐ Co-defendant ☐ Other _____

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Applicant Name: Cheryl Chastine Date: 11/20/12

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

RECEIVED
NOV 26 2012
KSBHA

Affidavit
And
Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

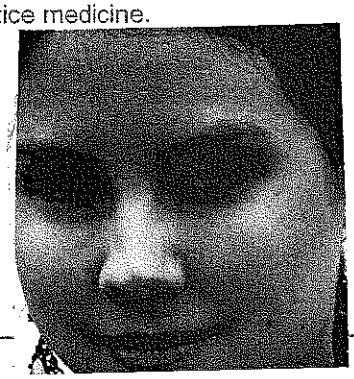
I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.



Cheryl Chastine
Applicant's Signature (must be signed in the presence of a notary)

Chastine
Applicant's Printed Last Name

Cheryl A
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

11/9/12
Date of Signature

NOTARY

Dated 11/9/12 Signed _____

State of Illinois County of Cook

SUBSCRIBED AND SWORN TO before me this 9th day of November 2012

My commission expires: 12/21/2015 (NOTARY PUBLIC SIGNATURE & SEAL)

"OFFICIAL SEAL"
ALEXANDER WEBB
Notary Public, State of Illinois
My Commission Expires 12/21/2015

Applicant Name: Cheryl Chastine Date: 11/12/12

Kansas State Board of Healing Arts
Addendum 1

Discipline applying for: (Check appropriate item)

☑ Medicine & Surgery ☐ Osteopathic Medicine & Surgery

License Designation: Please select the license designation you are requesting.

☑ Active — A license issued to a person engaged in the practice of medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry. Individuals must maintain and submit evidence of satisfactory completion of a program of continuing education and are required to have professional liability insurance in compliance with Kansas law. Each active license may be renewed annually.

☐ Federal Active — A license issued to only a person who meets all the requirements for a license to practice the healing arts in Kansas and who practiced that branch of the healing arts solely in the course of employment or active duty in the United States government or any of its departments, bureaus or agencies or who, in addition to such employment or assignment, provides professional services as a charitable health care provider as defined under K.S.A. 75-6102. Continuing education, expiration and renewal of a license shall be applicable to a federally active license. A person who practices under a federally active license shall not be deemed to be rendering professional service as a health care provider in this state and is not required to have policy of professional liability coverage in effect.

☐ Inactive — A license issued to a person who is not regularly engaged in the practice of the healing arts in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. An inactive license shall not entitle the holder to practice the healing arts in this state. Each inactive license may be renewed annually. The holder of an inactive license shall not be required to submit evidence of satisfactory completion of a program of continuing education and is not required to have basic coverage or self-insurance in effect solely because such person is no longer engaged in rendering professional service as a health care provider.

☐ Exempt — A license issued to a person who is not regularly engaged in the practice of the healing arts or podiatry in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. Each exempt license may be renewed annually. The holder of an exempt license is entitled to all the privileges of their branch of the healing arts and (1) may serve as a coroner or as a paid employee of a local health department as defined by K.S.A. 65-241; or (2) practice as a charitable health care provider for an indigent health care clinic as defined by K.S.A. 75-6102. Additionally, the holder of an exempt license may perform administrative functions. The holder of an exempt license shall not be required to submit evidence of satisfactory completion of a program of continuing education nor are they required to have basic coverage or self-insurance in effect. I acknowledge by marking the exempt check box, that with an exempt license I will not be a health care provider as defined by K.S.A. 40-3401, that I am not required to maintain professional liability insurance in accordance with K.S.A. 40-3401 and that services I render while a holder of an exempt license will not be insured or covered by the Health Care Stabilization Fund. I intend to engage in the following professional activities in Kansas:_____

Additional Information:

1. Have you ever been licensed to practice the Healing Arts in Kansas? ☐ Yes ☑ No
2. Give location of intended practice in Kansas 5101-5107 E Kellogg Dr, Wichita, KS 67218
3. Primary Specialty Family Medicine

   American Board Certified Y - ABFM American Board Eligible _____

Statement of Health:

4. Do you presently have any physical or mental problems or disabilities which could effect your ability to competently practice your particular branch of the healing arts or your particular specialty?

   ☐ Yes ☑ No

   If yes, applicant shall file with this application, a detailed statement of his/her health, diagnosis and prognosis, supported by a report from his/her attending physician including any medication and treatment currently prescribed.

Name (Printed or typed): Cheryl Chastine Date: 11/20/12

RECEIVED
NOV 16 2012
KSBHA

Form #2

Medical School Verification – Page 1 of 4
(Copy this form for multiple schools)

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to your medical school along with a copy of your diploma. Request the Dean or designated official to complete Section 3 of this form and return this form, the sealed copy of your diploma (to be sealed by your medical school) and a copy of your official transcripts directly to this Board.

Section 1: Applicant Information

Last Name: Chastine
First Name: Cheryl
Middle Name: Ann
Suffix:
Name if different when diploma awarded:
Social Security Number: Confidential
Date of Birth: Confidential 81

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the medical school below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

Cheryl A Chastine MD — Applicant's Signature
11/6/12 — Date

Section 2: Instructions to the Dean or designated official of medical school
Please complete Section 3 of this form, certify the enclosed copy of the above named applicant's diploma by placing your school seal on it, enclose an offical copy of the transcripts of the above named physician and forward all of this information directly to this Board to the following address:

Board Name: Kansas State Board of Healing Arts
Address 800 SW Jackson, Lower Level, Suite A
City Topeka
State/Province KS
ZIP Code 66612

RECEIVED Form #2
NOV 16 2012
KSBHA

Medical School Verification – Page 2 of 4
(Copy this form for multiple schools)

Section 3: Medical School Verification

Medical School Name: University of Kentucky College of Medicine
School name if different when the above applicant attended: _____
Medical School Address: 138 Leader Ave, Lexington, KY 40506
Street City State/Province ZIP Code

Hours of undergraduate education required for admission into your school: 4 yrs.
Applicant's Attendance Dates: From 08/01/05 To 05/14/09 Graduation Date: 05/16/09 Degree: MD
(Indicate N/A if not applicable) (Indicate N/A if not applicable)

Total weeks of education applicant attended your school: 163

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature: _____
Print name: Beth Hartmann, Registrar
Title: University of Kentucky College of Medicine
Date: 11/13/2012
Phone number: 8593232456 Fax: 8593232076
E-mail: Com.registrar@uky.edu

AFFIX INSTITUTIONAL SEAL HERE
(If no seal is available, this form must be notarized)

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

Form #2

Medical School Verification – Page 3 of 4
(Copy this form for multiple schools)

1. Does this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?

Response ☐ YES ☒ NO

If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

Please Specify: _____

2. Does this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response ☐ YES ☒ NO

If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
☐ Academic Probation		
☐ Probation for unprofessional conduct/behavioral reasons		
☐ Probation for other reason		

Please specify reason: _____

3. Does this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response ☐ YES ☒ NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s): _____

Applicant Name: _____ Date: _____

Medical School Verification – Page 4 of 4
(Copy this form for multiple schools)

4. Does this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? Response ☐ YES ☒ NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Does this individual's official records reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?
Response ☐ YES ☒ NO

If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

Applicant Name: _____ Date: _____

University of Kentucky

College of Medicine

To all who may read these letters, Greetings:

Hereby it is certified that, after the pursuit of studies, the passage of examinations required, and upon the recommendation of the University Senate, the Board of Trustees of the University of Kentucky, through the President, confers upon

Cheryl Ann Chastine

the degree of

Doctor of Medicine

With Distinction

with all the rights, privileges and honors pertaining thereto.

Dated this sixteenth day of May, 2009.

Lee T. Todd, Jr.
President of the University

Thomas Lee
Chairman, Board of Trustees

Jay Noel Perman
Dean of College

Donald E. Witt
University Registrar

It is hereby certified that this is a true copy of the original document issued by the University of Kentucky College of Medicine.

Beth Hartmann
College of Medicine Registrar
November 13, 2012

RECEIVED
NOV 16 2012
KSP

RECEIVED

DEC 1 0 2012

KSBHA

Form #3

Postgraduate Training Verification - Page 1 of 3
(Copy this form for multiple programs)

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to your training program. Request the Program Director or designated official to complete Section 3 of this form and return this form directly to this Board.

Section 1: Applicant Information

Last Name: Chastine

First Name: Cheryl

Middle Name: Ann

Suffix:

Name if different when diploma awarded: —

Social Security Number: Confidential

Date of Birth: Confidential 81

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Postgraduate Training Program below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

Applicant's Signature

11/6/12
Date

Section 2: Instructions to the PROGRAM DIRECTOR or designated official of POSTGRADUATE TRAINING PROGRAM.
Please complete Section 3 of this form and forward this information directly to this Board at the following address:

Board Name: Kansas State Board of Healing Arts

Address 800 SW Jackson, Lower Level, Suite A

City Topeka,

State/Province KS

ZIP Code 66612

Form #3

Postgraduate Training Verification - Page 2 of 3
(Copy this form for multiple programs)

Section 3: Postgraduate Training Verification

Institution Name: WEST SUBURBAN MEDICAL CENTER
Institution Address: 3 ERIE COURT
Street
City OAK PARK
State/Province IL
ZIP Code 60302

Affiliated Medical School Name: NOT APPLICABLE
Program Type/Specialty: FAMILY MEDICINE RESIDENCY
Postgraduate Year: PGY-1, PGY-2 AND PGY-3 SUCCESSFULLY COMPLETED.

☐ Internship ☑ Residency ☐ Fellowship ☐ Research ☐ Chief Resident
Other:
From Date: 07/01/2009 To Date: 06/30/2012

Successfully Completed?: ☑ Yes ☐ No ☐ In Progress
(The definition of Successfully Completed is: In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?)

Accredited by: ☑ ACGME ☑ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Did this individual ever take a leave of absence or break from his/her training?	☐ Yes	☑ No
Was this individual ever placed on probation?	☐ Yes	☑ No
Was this individual ever disciplined or placed under investigation?	☐ Yes	☑ No
Were any negative reports for behavioral reasons ever filed by instructors?	☐ Yes	☑ No
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	☐ Yes	☑ No

Please explain any "Yes" response from above (attach additional pages if necessary):

Applicant Name: Cheryl Chastine Date: 11/6/12

Form #3

Postgraduate Training Verification - Page 3 of 3

(Copy this form for multiple programs)

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature: S. Levin, M.D.

Print name: **Scott A. Levin, M.D., Program Director**

Title:

Date: 11/17/12

Phone number: 708-763-2369

Fax: 708-763-2162

E-mail: VISMITH@WESTSUBMC.COM

AFFIX INSTITUTIONAL SEAL HERE (If no seal is available, this form must be notarized)

Kansas State Board of Healing Arts
Addendum 2

Please answer each of the following questions by putting a check (✓) in the appropriate box. All "yes" answers MUST be thoroughly explained in detail in a separate signed page. You are required to furnish complete details including date, place, reason and disposition of the matter and attach all relevant documentation. All information received will be checked accordingly to verify the truth and veracity of your answers. It is imperative that you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant. If you are unsure of your response to a particular question, check (✓) the "yes" box and submit the appropriate form if required. Your responses on your application are evaluated as evidence of your candor and honesty. An honest "yes" answer to a question on your application is not definitive as to the Boards' assessment of your present moral character and fitness, but a dishonest "no" answer is evidence of a lack of candor and honesty, which may be definitive on the character and fitness issue. Please be advised that a false response to any of these questions may be grounds for denial of licensure and reported to the appropriate data banks. If a question is not applicable, then check (✓) the "no" box.

1. Have you ever been dropped, suspended, expelled, fined, placed on probation, allowed to resign, requested to leave temporarily or permanently, or otherwise had action taken against you by any professional training or educational program, including but not limited to medical school, prior to completing the training?
   ☐ Yes ☑ No
2. Have you ever had any application for any professional license refused or denied by any licensing authority?
   ☐ Yes ☑ No
3. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?
   ☐ Yes ☑ No
4. Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, suspended, revoked or placed on probation, or have you ever involuntarily or voluntarily (to avoid disciplinary action or investigation) resigned or withdrawn from any licensed hospital, nursing home, clinic or other health care facility in which you have trained, including but not limited to residency or postgraduate training programs, or otherwise been a staff member, been a partner or held privileges?
   ☐ Yes ☑ No
5. Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility?
   ☐ Yes ☑ No
6. Have you ever been requested to resign, withdraw or otherwise terminate your position with a partnership, professional association, corporation or other practice organization, either public or private?
   ☐ Yes ☑ No
7. Have you ever voluntarily surrendered any professional license?
   ☐ Yes ☑ No
8. Has any licensing authority ever limited, restricted, suspended, revoked, censured or placed on probation, or had any other disciplinary action taken against any professional license you have held?
   ☐ Yes ☑ No
9. Have you ever been notified or requested to appear before a licensing or disciplinary agency?
   ☐ Yes ☑ No
10. To your knowledge, have any complaints (regardless of status) ever been filed against you with any licensing agency, professional association, hospital, nursing home, clinic or other health care facility?
    ☐ Yes ☑ No
11. Has any professional association imposed any disciplinary action against you?
    ☐ Yes ☑ No
12. Within the past 2 years, have you used any alcohol, narcotic, barbiturate, or other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent?

Confidential

13. Within the past 2 years, have you been diagnosed or treated for any physical, emotional or mental illness or disease, including drug addiction or alcohol dependency, which limited your ability to practice the healing arts with reasonable skill and safety?

Confidential

14. Within the past 2 years, have you used controlled substances, which were obtained illegally or which were not obtained pursuant to a valid prescription order or which were not taken following the directions of a licensed health care provider?
Confidential

15. Have you ever practiced your profession while any physical or mental disability, loss of motor skill or use of drugs or alcohol, impaired your ability to practice with reasonable safety?
Confidential

16. Do you presently have any physical or mental problems or disabilities which could affect your ability to competently practice your profession?
☐ Yes ☑ No

17. Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration certificate or been called before or warned by any such agency or other lawful authority concerned with controlled substances?
☐ Yes ☑ No

18. Have you ever surrendered your state or federal controlled substances registration or had it revoked, suspended, or restricted in any way?
☐ Yes ☑ No

19. Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary agency?
☐ Yes ☑ No

20. Have you ever been arrested? Do not include minor traffic or parking violations or citations except those related to a DUI, DWI or a similar charge. You must include all arrests including those that have been set aside, dismissed or expunged or where a stay of execution has been issued.
☐ Yes ☑ No

21. Have you ever been charged with a crime, indicted, convicted of a crime, imprisoned, or placed on probation (a crime includes both Class A misdemeanors and felonies)? You must include all convictions including those that have been set aside, dismissed or expunged or where a stay of execution has been issued.
☐ Yes ☑ No

22. Have you ever been court-martialed or discharged dishonorably from the armed services?
☐ Yes ☑ No

23. Have you ever been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid in your behalf, or paid such claim yourself?
☐ Yes ☑ No

24. Have you ever been denied provider participation in any State Medicaid or Federal Medicare Programs or in a private insurance company?
☐ Yes ☑ No

25. Have you ever been terminated, sanctioned, penalized, or had to repay money to any State Medicaid or Federal Medicaid Programs or private insurance company?
☐ Yes ☑ No

Name (Printed or typed): Cheryl Chastine Date: 11/20/12

RECEIVED
NOV 26 2012
KSBHA

United States Medical Licensing Examination® (USMLE®)
Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 -- Telephone (817) 868-4000

Date : **11/09/2012**

Recipient:

Kansas State Board of Healing Arts
ATTN: Licensing Department
800 SW Jackson Lower Level-Suite A
Topeka, KS 66612

Examinee: Chastine, Cheryl
Alt Name(s): Chastine, Cheryl Ann

Examinee ID#: 5-194-539-2
Date of Birth: Confidential

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

			Three-Digit Score		Two-Digit Score		
	Test Date	**Pass/Fail**	**Total**	**MP**	**Total**	**MP**	**Comments**
	06/04/2007	Pass	Confidential				

USMLE STEP 2

Clinical Knowledge (CK)

			Three-Digit Score		Two-Digit Score		
	Test Date	**Pass/Fail**	**Total**	**MP**	**Total**	**MP**	**Comments**
	07/28/2008	Pass	Confidential				

Clinical Skills (CS)*

			Three-Digit Score		Two-Digit Score		
	Test Date	**Pass/Fail**	**Total**	**MP**	**Total**	**MP**	**Comments**
	09/08/2008	Pass					

USMLE STEP 3

			Three-Digit Score		Two-Digit Score		
	Test Date	**Pass/Fail**	**Total**	**MP**	**Total**	**MP**	**Comments**
KENTUCKY	06/20/2011	Pass	Confidential				

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

RECEIVED
JAN 10 2013
KSBHA

Pat Quinn
Governor

Manuel Flores
Acting Secretary

Jay Stewart
Director
Division of Professional Regulation

CERTIFICATION OF LICENSURE

January 7, 2013

KS Board of Healing Arts
800 SW Jackson Ste A
Topeka KS 66612

Licensee:	CHERYL ANN CHASTINE MD
License Number:	036.128802
Profession:	LICENSED PHYSICIAN AND SURGEON
Date of Issuance:	08/17/2011
Expiration Date:	07/31/2014
License Status:	ACTIVE
License Method:	ACCEPT EXAM-USMLE
Disciplinary History:	Has not been disciplined

Temporary certificate physician and surgeon no. 125.056559 was issued with a starting date of 07/01/2009. No disciplinary action on file. This was a medical residency training certificate only.

This document is a certified copy of the records maintained and kept by this Department in the regular course of business as of today's date.

IL DEPT. OF FINANCIAL & PROFESSIONAL REGULATION SEAL DIV. OF PROFESSIONAL REGULATION

#7

Jay Stewart
Director
Division of Professional Regulation

January 7, 2013
Date

Refer to the Department's Web Site at www.idfpr.com to verify professional licenses via License Look-Up.