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):

SS#:

Profession:

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.)

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.)

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

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.

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

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

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

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.

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.

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

How to Verify This Transaction

Every Notarize transaction is recorded and saved for a minimum of five years. Whether you receive an electronic or printed paper copy of a Notarize document, you can access details of the transaction and verify its authenticity with the information below.

To get started, visit verify.notarize.com and enter this information:

Notarize ID:	VUB59KCX
Access PIN:	7SVQCR

For more information on how to verify Notarize transactions, please visit:
support.notarize.com/notarize-for-signers/verifying-document-authenticity

Notarize

STATE OF WISCONSIN
Department of Safety and Professional Services
4822 Madison Yards Way
Madison WI 53708-8935

Governor Tony Evers **Secretary Dawn B. Crim**

Mail to:
PO Box 8935
Madison WI 53708-8935

Email: dsps@wisconsin.gov
Web: http://dsps.wi.gov
Phone: 608-266-2112

CERTIFICATION

DATE: 04/01/2022

I, Aloysius F. Rohmeyer, do hereby certify that I am the Record Custodian in the Department of Safety and Professional Services, a department of the government of the State of Wisconsin; that I am the custodian of the records relating to Medicine and Surgery, MD and its seal; that a standard search of the available records of this office indicates the following:

THIS IS TO CERTIFY THAT:	CHASTINE, CHERYL A
CREDENTIAL TYPE:	MEDICINE AND SURGERY, MD
WAS ISSUED LICENSE NO:	64087-20
STATUS:	CREDENTIAL LICENSE IS CURRENT (ACTIVE)
ISSUE DATE:	05/15/2015
EXPIRATION DATE:	10/31/2023

Credential Holder History

Date	Code	Description
10/02/2014	ENDORSED FROM	Endorsed from USMLE
05/31/2009	GRADUATED FROM	Graduated from University of Kentucky College of Medicine

According to our records, this credential holder has not been disciplined.

The information above is the only certification information provided by this Department. **We strongly encourage you to verify the license status of this individual by checking the DSPS online license look-up at http://app.wi.gov/licensesearch**. To expedite the certification process, the above format is the standard format for all professions regulated by this Department.

[redacted]

Aloysius F. Rohmeyer

Record Custodian
Department of Safety and Professional Services

Wolters Kluwer

UpToDate certifies that

Cheryl Chastine

has participated in the Internet point-of-care activity titled

UpToDate®

Mar 13, 2021 - Mar 06, 2022

and is awarded

35.0 AMA PRA Category 1 Credit(s)™

[redacted]

Peter Bonis, MD VP & Chief Medical Officer, Health Clinical Effectiveness

See reverse side for accreditation statements

Certificate 1047731902 (Mar 29, 2022)

Wolters Kluwer

UpToDate certifies that

Cheryl Chastine

has participated in the Internet point-of-care activity titled

UpToDate®

Mar 02, 2019 - Dec 10, 2019

and is awarded

32.0 AMA PRA Category 1 Credit(s)™

[redacted]

Denise S. Basow, MD President & CEO, Clinical Effectiveness

See reverse side for accreditation statements

Certificate 1116264403 (Mar 16, 2021)

Wolters Kluwer

UpToDate certifies that

Cheryl Chastine

has participated in the Internet point-of-care activity titled

UpToDate®

Dec 10, 2019 - Mar 06, 2021

and is awarded

50.0 AMA PRA Category 1 Credit(s)™

[redacted]

Denise S. Basow, MD President & CEO, Clinical Effectiveness

See reverse side for accreditation statements

Certificate 1116255803 (Mar 16, 2021)

UNITED STATES OF AMERICA

UpToDate is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

American Medical Association

UpToDate designates this Internet point-of-care activity for a maximum of 0.5 *AMA PRA Category 1 Credit(s)™*. Physicians should claim only credit commensurate with the extent of their participation in the activity. There is no limit to the number of Internet point-of-care cycles that physicians may complete using UpToDate.

American Academy of Family Physicians (AAFP)

The AAFP has reviewed UpToDate and deemed it acceptable for up to 20.00 Point of Care AAFP Prescribed credit. Term of Approval is from 10/31/2020 to 10/30/2021. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

American Academy of Pediatrics

This continuing medical education activity has been reviewed by the American Academy of Pediatrics and is acceptable for a maximum of 50.00 AAP credits. These credits can be applied toward the AAP CME/CPD Award available to Fellows and Candidate Members of the American Academy of Pediatrics.

American Academy of Physician Assistants

AAPA accepts certificates of participation for educational activities certified for Category I credit from ACCME, prescribed credit from AAFP, and *AMA PRA Category 1 Credit(s)™* from organizations accredited by ACCME or a recognized state medical society.

Physician assistants may receive a maximum of 0.5 hours of Category I credit for completing each Internet point-of-care learning cycle.

American Association of Nurse Practitioners

UpToDate is approved as a provider of nurse practitioner continuing education by the American Association of Nurse Practitioners: AANP Provider Number: 051212. This activity was planned in accordance with AANP Accreditation Standards and Policies.

For each hour of participation with the program, NPs can claim 1.0 contact hour. UpToDate automatically tracks the time you spend using the service.

American College of Emergency Physicians

Approved by the American College of Emergency Physicians for a maximum of 30 hour(s) of ACEP Category I credit.

American College of Obstetricians and Gynecologists (ACOG)

The American College of Obstetricians and Gynecologists has assigned up to 0.50 cognate credit per Internet point-of-care learning cycle.

There is no limit to the number of Internet point-of-care learning cycles that physicians may complete using UpToDate.

American Midwifery Certification Board (AMCB)

The Certificate Maintenance Program of the American Midwifery Certification Board (AMCB) accepts *AMA PRA Category 1 Credit™* and AANP NP contact hours, both of which UpToDate offers, to satisfy the 20 contact hours requirement. AMCB Certificants will be required to enter credit amount/upload credit certificate earned from use of UpToDate into the user portal on the AMCB's website in order to fulfill their continuing education requirement.

American Osteopathic Association (AOA)

UpToDate has been approved by the American Osteopathic Association for unlimited AOA Category 2-B credit.

American Board of Medical Specialties Continuing Certification Directory

Through the American Board of Medical Specialties ("ABMS") ongoing commitment to increase access to practice relevant Maintenance of Certification ("MOC") Activities through the *ABMS Continuing Certification Directory*, **UpToDate** has met the requirements as an **MOC Part II CME Activity** (apply toward general CME requirement) and/or an **MOC Part II Self-Assessment Activity** for the following ABMS Member Boards.

MOC Part II CME Activity

- American Board of Allergy and Immunology
- American Board of Colon and Rectal Surgery
- American Board of Family Medicine
- American Board of Physical Medicine and Rehabilitation
- American Board of Preventive Medicine
- American Board of Psychiatry and Neurology
- American Board of Thoracic Surgery

American Board of Anesthesiology (ABA) MOCA 2.0 Program

This activity contributes to the CME component of the American Board of Anesthesiology's redesigned Maintenance of Certification in Anesthesiology™ (MOCA®) program, known as MOCA 2.0®. Please consult the ABA website, www.theABA.org, for a list of all MOCA 2.0 requirements. *(Direct Credit Reporting)*

American Board of Dermatology (ABD) Maintenance of Certification Program

Dermatology related *AMA PRA Category 1 Credit™* earned from use of UpToDate may fulfill Part 2 CME Resources of the American Board of Dermatology MOC Program.

American Board of Internal Medicine (ABIM) Maintenance of Certification Program

Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to 0.5 Medical Knowledge MOC points per Internet point-of-care activity in the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program. Participants will earn MOC points equivalent to the amount of CME credits claimed for the activity. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABIM MOC credit. *(Direct Credit Reporting)*

American Board of Ophthalmology (ABO) Maintenance of Certification Program

Successful completion of this CME activity, which includes participation in the evaluation component, enables the learner to satisfy the Lifelong Learning, Self-Assessment, Improvement in Medical Practice and/or Patient Safety requirements for the American Board of Ophthalmology's Maintenance of Certification program. It is the CME activity provider's responsibility to submit learner completion information to ACCME for the purpose of granting MOC credit. *(Direct Credit Reporting)*

American Board of Otolaryngology – Head and Neck Surgery (ABOHNS) Continuing Certification Program

Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn their required annual part II self-assessment credit in the American Board of Otolaryngology – Head and Neck Surgery's Continuing Certification program (formerly known as MOC). It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of recognizing participation. *(Direct Credit Reporting)*

American Board of Pathology (ABPath) Continuing Certification Program

Successful completion of this CME activity enables the participant to earn up to 0.5 Lifelong Learning points per Internet point-of-care activity in the American Board of Pathology's (ABPath) Continuing Certification program. Participants will earn points equivalent to the amount of CME credits claimed for the activity. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of recognizing participation. *(Direct Credit Reporting)*

American Board of Surgery

Credits earned from use of UpToDate may fulfill Part 2 CME requirements of the American Board of Surgery MOC Program.

National Board of Physicians and Surgeons (NBPAS)

Credits earned from use of UpToDate may fulfill CME and certification requirements for the NBPAS.

AUSTRALIA/NEW ZEALAND

Australasian College of Dermatologists (ACD)

Time spent reading UpToDate may be claimed on the basis of 1 point per hour in Category 1 Level 1 Personal Reading and Study (Activity code STUDY) of the ACD CPD Program.

Australian and New Zealand College of Anaesthetists (ANZCA) and Faculty of Pain Medicine (FPM)

Time spent reading UpToDate may be claimed as a Journal reading activity in the Knowledge and skills category at one credit per hour, maximum of 10 credits per year of the 2014 ANZCA and FPM CPD Program.

Australian College of Rural & Remote Medicine (ACRRM)

Time spent reading UpToDate may be claimed on the basis of 1 core point per hour in the Self-directed Learning category of the ACRRM Professional Development Program.

Inpractice (New Zealand)

Doctors registered in the Inpractice programme may claim time spent reading UpToDate as part of their continuing medical education requirement. CME activities must be recorded in the ePortfolio including relevance to PDP goal, what was learnt, and benefit to patients.

Royal Australian College of General Practitioners

Time spent reading UpToDate may be claimed on the basis of 2 points per hour in the Self Recorded Activities category of the RACGP QI & CPD Program.

Royal Australasian College of Physicians (RACP)

RACP Fellows may claim their UpToDate reading as CPD credits in the MyCPD program.

Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Time spent reading UpToDate may be claimed on the basis of 1 point per hour in the Self-Education category of the RANZCOG CPD Program.

Royal New Zealand College of General Practitioners

Time spent researching clinical topics on UpToDate may be claimed, on the basis of 1 point per hour spent, in the Continuing Medical Education category as individually planned learning. To claim these credits, an RNZCGP Learning Reflection form must be completed and saved for your records.

Royal New Zealand College of Urgent Care (RNZCUC)

Time spent reading UpToDate may be claimed as part of the CPD activities required for recertification at 1 point per hour. The RNZCUC will accept a maximum of 5 points earned from use of UpToDate per year.

Psychiatrists and Surgeons

To claim points for this activity, please refer to the CPD requirement of your relevant organization.

AUSTRIA

Austrian Academy of Physicians

The Austrian Academy of Physicians of the Austrian Medical Chamber recognizes programs accredited by the Accreditation Council for Continuing Medical Education (ACCME). Physicians may submit their credits earned from UpToDate toward their DFP e-learning requirements. One credit earned from UpToDate is equal to 1 DFP point.

BELGIUM

National Institute for Health and Disability Insurance

The Accrediteringsstuurgroep/Groupe de direction d'accréditation of the National Institute for Health and Disability Insurance (NIHDI) recognizes programs that offer *AMA PRA Category 1 Credit(s)™*. Physicians may submit their credits earned from UpToDate toward their CME/CPD requirements. Each learning cycle accumulates 0.5 credits and there is no limit to the number of UpToDate credits that can be submitted toward requirements.

BRAZIL

Sociedade Brasileira de Nefrologia (SBN)

The Sociedade Brasileira de Nefrologia (SBN) recognizes UpToDate as a distance education program. Time spent reading UpToDate may be claimed towards EMC (continuing medical education) on the basis of 1 hour of reading equals 1 point of learning. The SBN and Brazilian Medical Association will accept a maximum of 5.5 points earned from use of UpToDate per year.

CANADA

College of Family Physicians of Canada

This **Self-Learning** program has been certified by the College of Family Physicians of Canada for up to 0.5 Mainpro+ Certified Self-Learning Credit per Internet point-of-care learning cycle for a maximum of 250 Mainpro+ certified credits (CERT+ Session ID# 192150-001).

Royal College of Physicians and Surgeons of Canada

Use of UpToDate may be recorded on the basis of 0.5 credits per activity in **Section 2** of the Royal College's MOC Program.

Through an agreement between the Accreditation Council for Continuing Medical Education and the Royal College of Physicians and Surgeons of Canada, medical practitioners participating in the Royal College's MOC Program may record completion of accredited activities registered under the ACCME's "CME in Support of MOC" program in **Section 3** of the Royal College's MOC Program.

COLOMBIA

Asociación Colombiana de Facultades de Medicina (ASCOFAME)

The Permanent Professional Development Program (DPP) of Asociación Colombiana de Facultades de Medicina (ASCOFAME), which has been operating since 2002, recognizes UpToDate as a valuable learning activity. Each completed UpToDate learning cycle accumulates 0.5 credits that may be claimed as Category C credits (knowledge activities) under the DPP system.

ECUADOR

Colegio Médico de Pichincha

Colegio Médico de Pichincha recognizes UpToDate as a continuing education program. Time spent reading UpToDate, with a maximum of 10 minutes per topic, may be claimed by clinicians towards CME as defined by their specialty accrediting body.

GERMANY

Physician Chamber of North Rhine

UpToDate is recognized as a provider of micro e-learning under the Chamber's accreditation criteria. One credit point is awarded for 60 minutes of education completed. This recognition begins January 1, 2018. Points may be redeemed for up to 5 years from the time they were accrued.

HONG KONG

Hong Kong College of Physicians (HKCP)

Use of UpToDate may be claimed on the basis of 0.5 points per internet point of care learning cycle activity of Active CME/CPD. A maximum of 60 points per 3-year cycle may be submitted.

IRELAND

Certificates from the ACCME-accredited activity UpToDate are recognized by the Postgraduate Medical Training Bodies in Ireland and can be recorded as External CPD. Each learning cycle accumulates 0.5 credits.

ITALY

Age.na.s National ECM Program (National Commission for Continuing Education/National Agency for Regional Health Services)

Credits earned from the use of UpToDate (Foreign Provider) may be submitted to your college/professional association and will be recognized up to a maximum of 50% of the credit awarded and be incorporated into your ECM record. Of the 150 credits clinicians need over a 3-year period, half of the credits can come from Foreign Providers. For credits to be acknowledged by your college/professional association, please submit both your credit certificate and activity log. For more information, refer to the official Age.na.s regulations: http://age.agenas.it/ecm/normativa.aspx and http://age.agenas.it/provider/documenti-provider.aspx.

CERTIFICATE OF PHYSICIAN ATTENDANCE

NATIONAL ABORTION FEDERATION

NAF's 43rd Annual Meeting

May 6-7, 2019 — Chicago, Illinois

The National Abortion Federation is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The National Abortion Federation designates this live activity for a maximum of 13.5 *AMA PRA Category 1 Credits.™* Physicians should claim only the credit commensurate with the extent of their participation in the activity.

NAF certifies that

Cheryl Chastine, MD

(Name of physician)

has participated in the educational activity titled "NAF's 43rd Annual Meeting" on May 6-7, 2019, and is awarded 13.5 *AMA PRA Category 1 Credits.™*

The American College of Obstetricians and Gynecologists has assigned up to 14 cognate credits to this program. This Live activity, NAF's 43rd Annual Meeting, with a beginning date of 05/06/2019, has been reviewed and is acceptable for up to 13.50 Prescribed credit(s) by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

[redacted]

Alice Mark, MD
Medical Director

[redacted]

Sue Carlisle, PhD, MD
Chair, Board of Directors

CERTIFICATE OF PHYSICIAN ATTENDANCE

NATIONAL ABORTION FEDERATION

Developing, Supporting, and Retaining our Human Resources Workshop

May 5, 2019 — Chicago, Illinois

The National Abortion Federation is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The National Abortion Federation designates this live activity for a maximum of 6.5 *AMA PRA Category 1 Credits.™* Physicians should claim only the credit commensurate with the extent of their participation in the activity.

NAF certifies that

Cheryl Chastine, MD

(Name of physician)

has participated in the educational activity titled "Developing, Supporting, and Retaining our Human Resources Workshop" on May 5, 2019, and is awarded 6.5 *AMA PRA Category 1 Credits.™*

The American College of Obstetricians and Gynecologists has assigned up to 7 cognate credits to this program. This Live activity, Developing, Supporting, and Retaining our Human Resources Workshop, with a beginning date of 05/05/2019, has been reviewed and is acceptable for up to 6.75 Prescribed credit(s) by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

[redacted]

Alice Mark, MD
Medical Director

[redacted]

Sue Carlisle, PhD, MD
Chair, Board of Directors

CERTIFICATE OF PHYSICIAN ATTENDANCE

NATIONAL ABORTION FEDERATION

Advanced Second –Trimester Abortion Workshop

May 4, 2019 — Chicago, Illinois

The National Abortion Federation is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The National Abortion Federation designates this live activity for a maximum of 6.5 *AMA PRA Category 1 Credits.™*
Physicians should claim only the credit commensurate with the extent of their participation in the activity.

NAF certifies that

Cheryl Chastine, MD

(Name of physician)

has participated in the educational activity titled "Advanced Second-Trimester Abortion Workshop" on May 4, 2019, and is awarded 6.5 *AMA PRA Category 1 Credits.™*

The American College of Obstetricians and Gynecologists has assigned up to 7 cognate credits to this program. This Live activity, Advanced Second-Trimester Abortion Workshop, with a beginning date of 05/04/2019, has been reviewed and is acceptable for up to 6.25
Prescribed credit(s) by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

[redacted]

Alice Mark, MD
Medical Director

[redacted]

Sue Carlisle, PhD, MD
Chair, Board of Directors

BOARD VITALS™

CERTIFICATE

BoardVitals certifies that

CHERYL CHASTINE, MD
BOARD ID: 153829

has participated in the CME activity titled:

FAMILY MEDICINE

from FEBRUARY 26, 2021 to MARCH 04, 2021

and is awarded

3 AMA PRA CATEGORY 1™ CREDIT(S)

BoardVitals is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

BoardVitals designates this Internet Enduring Material for a maximum of 40 *AMA PRA Category 1™ Credit(s)*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

ACCME ACCREDITED

Certificate ID: 52977

BoardVitals, 1350 Broadway, New York, NY 10018
Phone: (877) 221-1529 I Email: support@boardvitals.com I boardvitals.com

BOARD VITALS™

CERTIFICATE

BoardVitals certifies that

CHERYL CHASTINE, MD
BOARD ID: 153829

has participated in the CME activity titled:

FAMILY MEDICINE ELECTIVE CREDITS

from FEBRUARY 26, 2021 to MARCH 04, 2021

and is awarded

8 ELECTIVE CREDIT(S)

This Enduring Material activity, Online Family Medicine Question Bank Based On The ABFM Blueprint, has been reviewed and is acceptable for up to 100.00 Elective credit(s) by the American Academy of Family Physicians. AAFP certification begins 02/24/2020. Term of approval is for one year from this date. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

ACCME ACCREDITED

Certificate ID: 52976

BoardVitals, 1350 Broadway, New York, NY 10018
Phone: (877) 221-1529 I Email: support@boardvitals.com I boardvitals.com

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

The American Board of Family Medicine
Certificate of Successful Completion

Dr. Cheryl Chastine

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.

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

The American Board of Family Medicine
Certificate of Successful Completion

Dr. Cheryl Chastine

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.

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

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

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

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

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 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
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
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#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

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 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
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)