Lake County Health Department and Community Health Center
Provider Checklist
(To be completed by Medical Staff Office Specialist)

☒ Initial Appointment and Privileging 2026

Provider Name: Kyle Potts MD Specialty: Internal Medicine/Pulmonary Disease/Critical Care Medicine

☐ FT **☐ PT** **☒ FLEX**

☒ State of IL Credentialing Application

☒ CV

☒ IL License / CDS / DEA

☒ Privileging Form

☒ TB Test / Hep-B / Flu

☒ Driver's License

☒ 3 Peer References

☒ CME / CEU Acknowledgement

☒ Board Certification(s) (NA for dental)

☒ Release / Authorization Forms

☒ Diplomas and Certifications

☒ CPR Certification

☒ BOH Credentialing Committee Provider Summary Sheet

☒ Sex Offender Registry

☒ Official Transcripts (highest level completed)

☒ National Practitioner Data Bank (NPDB)
(Medical malpractice litigation)

☒ IL Dept of Finance & Prof. Regulation (IDFPR)
(Current licensure)

☒ Drug Enforcement Administration
(Diversion Control Division)

☒ Office of Inspector General (OIG)
(Convictions for program-related fraud, patient abuse, licensing board actions, health assistance loan default)

☒ American Medical Association (AMA) or American Osteopathic Information Association (AOIA) (MD/DO only) (D/DO only)
(Med school graduation, residency training specialty, board certification)

Reviewed and Completion Confirmed by: Sandra Montejano 6/10/2026

Sandra Montejano, Medical Staff Office Specialist Date

BOARD OF HEALTH CREDENTIALING COMMITTEE & GOVERNING COUNCIL PERSONNEL COMMITTEE
PROVIDER INFORMATION SUMMARY
Doctor of Medicine (MD) and Doctor of Osteopathic Medicine (DO)

SECTION A: PROVIDER INFORMATION		
First Name: Kyle	Middle Initial: J	Last Name: Potts
Degree/Title: MD		
Language(s) spoken: English		
Specialty: Internal Medicine	Board Certified? Y☒ N☐	If Y, certifying board? American Board of Internal Medicine
If N, board eligible? Y☐ N☐		If Y, exam date: 2019
Subspecialty: Pulmonary Disease and Critical Care Medicine	Board Certified? Y☒ N☐	Certifying Board: American Board of Internal Medicine
LCHD Clinic Site(s): (this field to be completed by LCHD credentialing staff) Tuberculosis Clinic / Waukegan / IL		

SECTION B: EDUCATION & TRAINING		
Medical School Name/City/State: UT Houston, McGovern Medical School / Houston / Tx		
Degree: MD	Year Graduated: 2016	
International Medical Graduate? Yes No If Yes, ECFMG certification date: _____ USMLE date: _____		
Internship Name /City/State: Internal Medicine- University of Colorado / Boulder / Colorado	From: 6/2016	To: 06/2017
Residency 1 Name/City/State: Internal Medicine- University of Colorado / Boulder / Colorado	From: 06/2017	To: 06/2019
Fellowship Name/City/State: Pulmonary Disease and Critical Care Medicine -University of Chicago / Chicago / IL	From: 06/2020	To: 06/2023

SECTION C: WORK HISTORY		
Last place of employment (name/city/state): Advocate Aurora, Christ Medical Center / Oaklawn / IL		
Title or professional occupation: Attending Physician, Critical Care Intensivist	From: 07/2024	To: Present
Previous place of employment (name/city/state): Northwest Pulmonary Associates		
Title or professional occupation: Attending Physician, Pulmonary and Critical Care	From: 07/2023	To: 08/2024
Previous place of employment (name/city/state):		
Title or professional occupation:	From:	To:

Why do you want to join the Lake County Health Department? (to be completed by new providers only)

I am interested in joining the Lake County Health Department due to my longstanding interest and commitment to the prevention, diagnosis and treatment of disease, especially respiratory infections(tuberculosis). Throughout my medical training I have been
particularly interested in pulmonary populations. I am eager to contribute my clinical skills to a multidisciplinary team dedicated to improving patient outcomes, reducing disease transmission, and advancing community health. Lake County Health department will allow me to combine my passion for tuberculosis care with my commitment to public service and evidence-based medicine.

Lake County Health Department and Community Health Center
3010 Grand Ave.
Waukegan, IL 60085
Phone: (847) 377-8098 Fax: (847) 984-5577

[X] **FQHC** [ ] **CMHC** [ ] **SUPR** [X] **Prevention**

MEDICAL STAFF

CLINICAL DELINEATION OF PRIVILEGES FOR INTERNAL MEDICINE

[X] **Initial Appointment** [ ] **Reappointment** [ ] **Revision**
(you **must** select one)

Name (Last/First/Middle): Potts, Kyle Jeffrey MD

Qualifications: Candidates must have an active license to practice Medicine and Surgery in Illinois.Current certification or eligibility in the process leading to certification in general internal medicine by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine. Successful completion of an accredited ACGME or AOA residency program in internal medicine.

Procedures: Successful completion of an approved, recognized course when such exists, or acceptable supervised training in residency, fellowship to other acceptable programs, and demonstration of indications for the procedure/test/therapy, and documentation of competence to obtain and retain clinical privileges.

Reappointment Requirements: Current clinical competence.

Applicant: Place a check mark in the **R** column for each privilege requested.

Reviewer: Place a check mark in either the **A**, **C**, or **N** column for each privilege requested based on the following:
A = Recommended as Requested / **C** = Recommended w/ Conditions / **N** = Not Recommended

R	CORE PRIVILEGES	A	C	N
x	To work-up, diagnose, and provide nonsurgical treatment, including consultation for patients 18 and over or in need of care to treat general medical problems.	x		

R	PROCEDURES Physicians with these privileges are expected to demonstrate both the skill to perform the procedure and ability to manage procedurally related complications. These privileges may include:	A	C	N
	Other:			

☐ The following is a list of **NEW** privileges with proof of competence attached:

1. _____

2. _____

3. _____

☐ The following is a list of privileges **DELETED** since the last application:

1. _____

2. _____

3. _____

ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those specific clinical privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform and wish to exercise at Lake County Health Department and Community Health Center.

I understand that:

(a) In exercising any clinical privileges granted, I am constrained by any Lake County Health Department and Community Health Center policies and rules generally applicable and/or applicable to the particular situation.

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable Community Standards of Medical Care.

KL Potts — 5/12/2026

Applicant Signature — Date

SIGNATURE PAGE

Applicant Name: Kyle Potts, MD Privileges Effective: 7/22/2026 to 7/21/2028

Rationale for revision (if applicable):

Privileges indicated are approved with the exception of the following:

Consultation required on the following:

Documentation regarding performance requested on the following:

I have reviewed credentialing information, peer reviews and supervisor confirmation and verified that the licensed independent practitioner named above is competent to perform the requested privileges and fit to perform the duties of the job in a safe, secure, and effective manner.

Signed by: Carmne Macias Huerta 152B0C783CF54E4...

Signature of Director of Provider Operations	Date	Printed Name
	6/9/2026 | 11:05 AM CDT	Carmne Macias Huerta

Signed by: Nuha Shair 0622385E7164447...

Signature of Medical Director	Date	Printed Name
	6/30/2026 | 11:35 AM CDT	Nuha Shair

Signature of Board of Health President	Date	Printed Name

Signature of Governing Council Chair	Date	Printed Name

Signature of Executive Director	Date	Printed Name

Lake County Health Department and Community Health Center
Provider Checklist
(To be completed by Medical Staff Office Specialist)

☒ **Initial Appointment and Privileging 2026**

Provider Name: Emily Tobias APRN Specialty: Family Nurse Practitioner

☐ **FT** ☒ **PT** ☐ **FLEX**

☒ State of IL Credentialing Application

☒ CV

☒ IL License
RN / APRN / CDS / DEA

☒ Privileging Form

☒ TB Test / Hep-B / Flu

☒ Driver's License

☒ 3 Peer References

☒ CME / CEU Acknowledgement

☒ Board Certification / Recertification

☒ Release / Authorization Forms

☒ CPR Certification

☒ BOH Credentialing Committee Provider Summary Sheet

☒ Sex Offender Registry

☒ Degree / Transcripts from an Accredited Program

☒ National Practitioner Data Bank (NPDB)
(Medical malpractice litigation)

☒ IL Dept of Finance & Prof. Regulation (IDFPR)
(Current licensure)

☒ Drug Enforcement Administration
(Diversion Control Division)

☒ Office of Inspector General (OIG)
(Convictions for program-related fraud, patient abuse, licensing board actions, health assistance loan default)

Reviewed and Completion Confirmed by: Sandra Montejano 6/10/2026

Sandra Montejano, Medical Staff Office Specialist Date

BOARD OF HEALTH CREDENTIALING COMMITTEE & GOVERNING COUNCIL PERSONNEL COMMITTEE
PROVIDER INFORMATION SUMMARY
Advanced Practice Registered Nurse (APRN)

SECTION A: PROVIDER INFORMATION		
First Name: **Emily**	Middle Initial: **C**	Last Name: **Tobias**
Degree(s), License, and APRN Certification: **BSN, DNP, FNP-C**		
Language(s) spoken: **English**		
Name of certification examination: **Family Nurse Practitioner**		Certifying Body/Organization: **American Academy of Nurses Practitioners National Certification Board**
APRN Certification Start Date: **06/13/2017**		APRN Certification Expiration Date: **06/12/ 2027**
IL APRN License Number: **209025294** Expiration Date: **5/31/2028**		Full Practice Authority: Y ☐ N ☒ If N: Name of LCHD Collaborating Physician: **Zahedi, Syeda MD**
IL RN License Number: **041524696** Expiration Date: **5/31/2028**		
LCHD Clinic Site(s): (this field to be completed by LCHD credentialing staff) **Belvidere Medical Building / Waukegan / IL**		

SECTION B: EDUCATION & TRAINING	
APRN Accredited Academic Institution Attended: School Name/City/State: **University of Missouri Columbia / Columbia / Missouri**	
Degree: **DNP, FNP**	Year Graduated: **2017**
New APRN graduate: List the dominant areas of clinical focus during your APRN training:	
Experienced APRN: List the dominant areas of APRN Practice and Expertise: **Urgent Care, Primary Care, Reproductive/Sexual Health, Women's Health**	
Academic degree(s): Check or list any other academic degrees that you have earned: BSN: __X____ MSN:_____ DNP: __X_____ PhD: ____ Other: _____	
Degree/Name of School/City/State of each of the above that are checked: **My BSN is from Truman State University in Kirksville, Missouri**	
Year of initial RN licensure: **2009**	Years practicing as RN (before APRN): **8**
RN Experience: List your dominant areas of RN practice and expertise: **Medical/Surgical, Emergency Room, Telemetry**	

SECTION C: WORK HISTORY		
Last place of employment (name/city/state): **Planned Parenthood of Illinois / Aurora / Illinois**		
Title or professional occupation and clinical practice area(s): **Advanced Practice Nurse**	From: **07/22**	To: **4/24**
Previous place of employment (name/city/state): **Favor Medical Group / San Mateo / California**		
Title or professional occupation and clinical practice area(s): **Family Nurse Practitioner**	From: **10/20**	To: **10/22**
Previous place of employment (name/city/state): **Med First Primary and Urgent Care / New Bern / North Carolina**		
Title or professional occupation and clinical practice area(s): **Family Nurse Practitioner**	From: **10/20**	To: **03/22**
Last place of employment (name/city/state): **Minute Clinic Diagnostic Medical Group / San Diego / California**		
Title or professional occupation and clinical practice area(s): **Family Nurse Practitioner**	From: **01/19**	To: **03/20**
Previous place of employment (name/city/state): **Baptist Physician's, MedFirst Primary Care / Schertz / Texas**		
Title or professional occupation and clinical practice area(s): **Family Nurse Practitioner**	From: **11/17**	To: **12/18**
Previous place of employment (name/city/state): **Complete Care Urgent Care / Lakeway / Texas**		
Title or professional occupation and clinical practice area(s): **Family Nurse Practitioner**	From: **10/17**	To: **12/18**
Last place of employment (name/city/state):		
Title or professional occupation and clinical practice area(s):	From:	To:
Previous place of employment (name/city/state):		
Title or professional occupation and clinical practice area(s):	From:	To:
Previous place of employment (name/city/state):		
Title or professional occupation and clinical practice area(s):	From:	To:

Why do you want to join the Lake County Health Department? (to be completed by new providers only)

I always imagined I would work for a health department or public health facility. My first job as a Registered Nurse was in a Level 1 Trauma Center in St. Louis, Missouri. While working there, I cared for many patients who had limited access to basic health care. This was often why they ended up seeking care in the Emergency Department. I saw the need for access as a priority and number one motivator to return to school and pursue my APRN. I additionally had a very close friend, who also without health insurance, and with a preexisting condition making it expensive to purchase a plan- received care from a free clinic in St. Louis Missouri. It was through this clinic he was able to receive his lifesaving Epilepsy medication.

I started my FNP program with Mizzou in 2012 and around the same time had an opportunity to take a Travel Nurse position in Kodiak, Alaska. While there I was drawn to the Native Alaska population, the health disparities the men, women, and children in the area suffered from- more so due to lack of access and knowledge. There was such an opportunity I felt, to educate and improve health outcomes for the area. I was able to complete most of my clinical rotations not only in Kodiak, but also in a two very rural fishing towns- Homer and Naknek. I additionally completed my DNP project in Kodiak, which was focused on improving communication, trust, and knowledge about contractive method options for providers and patients.

In summary, I have always wanted to work in this setting. My family and husbands' career in the Navy has required me to work and seek employment where I could fit it in for the last near decade. I am more than excited to prioritize my passion to work for and serve my community and contribute to improving health outcomes for residents of Lake County.

Lake County Health Department and Community Health Center
3010 Grand Ave.
Waukegan, IL 60085
Phone: (847) 377-8098 Fax: (847) 984-5577

[X] **FQHC** [ ] **CMHC** [ ] **SUPR** [ ] **Prevention**

MEDICAL STAFF

CLINICAL DELINEATION OF PRIVILEGES FOR ADVANCED PRACTICE REGISTERED NURSE (APRN) OR CERTIFIED NURSE MIDWIFE (CNM)

[X] **Initial Appointment** [ ] **Reappointment** [ ] **Revision**
(you **must** select one)

Name (Last/First/Middle): Tobias/Emily/C

Qualifications: Candidates must have an active license to practice as an Advanced Practice Nurse in Illinois and certification and/or recertification in the APRN specialty track.

Procedures: Successful completion of an accredited masters or doctoral program in the APRN specialty track and, recognized course when such exists, or acceptable supervised training in programs with accreditation, and demonstration of indications for the procedure/test/therapy, and doc umentation of competence to obtain and retain clinical privileges.

Reappointment Requirements: Current clinical competence.

Applicant: Place a check mark in the **R** column for each privilege requested.

Reviewer: Place a check mark in either the **A**, **C**, or **N** column for each privilege requested based on the following:
A = Recommended as Requested / **C** = Recommended w/ Conditions / **N** = Not Recommended

R	CORE PRIVILEGES	A	C	N
X	Collaborative Practice	X		
	Full Practice Authority			
X	Provide Family Planning Services	X		
	Provide Prenatal Care			
X	To evaluate, diagnose, consult, and treat pediatric patients from the age of 0-18 years	X		
X	To work-up, diagnose, and provide nonsurgical treatment, including consultation for patients 18 and above or in need of care to treat general medical problems.	X		

R	PROCEDURES APRNs or CNMs with these privileges are expected to demonstrate both the skill to perform the procedure and ability to manage procedurally related complications. These privileges may include:	A	C	N
X	Cryotherapy	X		
X	Nexplanon insertion and removal	X		
	I & D of Abscess			
X	Cauterization of umbilical granuloma	X		
X	Other: IUD insertion and removal	X		

The following is a list of **NEW** privileges with proof of competence attached:

1. _____

2. _____

3. _____

☐

The following is a list of privileges **DELETED** since the last application:

1. _____

2. _____

3. _____

☐

ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those specific clinical privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform and wish to exercise at Lake County Health Department and Community Health Center.

I understand that:

(a) In exercising any clinical privileges granted, I am constrained by any Lake County Health Department and Community Health Center policies and rules generally applicable and/or applicable to the particular situation.

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable Community Standards of Medical Care.

Digitally signed by Emily Tobias
Date: 2026.05.20 13:43:42 -05'00'

05/19/26

Applicant Signature | Date

SIGNATURE PAGE

Applicant Name: Emily Tobias Privileges Effective: 7/22/2026 to 7/21/2028

Rationale for revision (if applicable):

Privileges indicated are approved with the exception of the following:

Consultation required on the following:

Documentation regarding performance requested on the following:

I have reviewed credentialing information, peer reviews and supervisor confirmation and verified that the licensed independent practitioner named above is competent to perform the requested privileges and fit to perform the duties of the job in a safe, secure, and effective manner.

Signed by: Toni Steres XTQEXFBFDD2... Signature of Director of Provider Operations	6/9/26 Date	Toni Steres Printed Name
Signed by: Nuha Shair 0622385E71644A7... Signature of Medical Director	6/30/2026 | 1:56 PM CDT Date	Nuha Shair Printed Name
Signature of Board of Health President	Date	Printed Name
Signature of Governing Council Chair	Date	Printed Name
Signature of Executive Director	Date	Printed Name

Lake County Health Department and Community Health Center
Provider Checklist
(To be completed by Medical Staff Office Specialist)

☒ **Initial Appointment and Privileging 2026**

Provider Name: Michelle Riggins FPA APRN Specialty: Family Nurse Practitioner

☐ **FT** ☐ **PT** ☒ **FLEX**

☒ State of IL Credentialing Application

☒ CV

☒ IL License
RN / APRN / CDS / DEA

☒ Privileging Form

☒ TB Test / Hep-B / Flu

☒ Driver's License

☒ 3 Peer References

☒ CME / CEU Acknowledgement

☒ Board Certification / Recertification

☒ Release / Authorization Forms

☒ CPR Certification

☒ BOH Credentialing Committee Provider Summary Sheet

☒ Sex Offender Registry

☒ Degree / Transcripts from an Accredited Program

☒ National Practitioner Data Bank (NPDB)
(Medical malpractice litigation)

☒ IL Dept of Finance & Prof. Regulation (IDFPR)
(Current licensure)

☒ Drug Enforcement Administration
(Diversion Control Division)

☒ Office of Inspector General (OIG)
(Convictions for program-related fraud, patient abuse, licensing board actions, health assistance loan default)

Reviewed and Completion Confirmed by: Sandra Montejano 6/18/2026

Sandra Montejano, Medical Staff Office Specialist Date

BOARD OF HEALTH CREDENTIALING COMMITTEE & GOVERNING COUNCIL PERSONNEL COMMITTEE
PROVIDER INFORMATION SUMMARY
Advanced Practice Registered Nurse (APRN)

SECTION A: PROVIDER INFORMATION		
First Name: **Michelle**	Middle Initial: **F**	Last Name: **Riggins**
Degree(s), License, and APRN Certification: **MSN-Master of Science in Nursing, FPA-APRN, Family Nurse Practitioner**		
Language(s) spoken: **English**		
Name of certification examination: **Family Nurse Practitioner**		Certifying Body/Organization: **American Academy of Nurse Practitioners**
APRN Certification Start Date: **09/13/2016**		APRN Certification Expiration Date: **09/12/2026**
IL APRN License Number: **277001422** Expiration Date: **05/31/2028**		Full Practice Authority: Y ☒ N ☐ If N: Name of LCHD Collaborating Physician:
IL RN License Number: **041371044** Expiration Date: **05/31/2028**		
LCHD Clinic Site(s): (this field to be completed by LCHD credentialing staff) **HD-BH-ATP (Addiction Treatment Program)**		

SECTION B: EDUCATION & TRAINING	
APRN Accredited Academic Institution Attended: School Name/City/State: **Chamberlain College of Nursing / Downers Grove / IL**	
Degree: **MSN Master of Science in Nursing**	Year Graduated: **2016**
New APRN graduate: List the dominant areas of clinical focus during your APRN training: **Family Nurse Practitioner**	
Experienced APRN: List the dominant areas of APRN Practice and Expertise: **Hospital Medicine, Urgent Care, Chronic Management**	
Academic degree(s): Check or list any other academic degrees that you have earned: BSN: __X____ MSN _X____DNP: _____ PhD: ____ Other: **AAS Associates Applied Science**	
Degree/Name of School/City/State of each of the above that are checked: **AAS: Prairie State College / Chicago Heights / IL**	
BSN: Chamberlain College of Nursing / Downers Grove / IL	
MSN: Chamberlain College of Nursing / Downers Grove / IL	
Year of initial RN licensure: **2008**	Years practicing as RN (before APRN): **8 yrs**
RN Experience: List of your dominant areas of RN practice and expertise: **ICU, ER, Special Procedures, ICU-step down, Med Surg, Dialysis**	

SECTION C: WORK HISTORY		
Last place of employment (name/city/state): **Franciscan Health-Specialty Physicians of Illinois / Chicago Heights / IL**		
Title or professional occupation and clinical practice area(s): **Nurse Practitioner – Urgent care**	From: **09/2025**	To: **03/2026**
Previous place of employment (name/city/state): **Swedish Covenant -Northshore / Chicago / IL**		
Title or professional occupation and clinical practice area(s): **Nurse Practitioner - Hospitalist**	From: **03/2020**	To: **03/2024**
Previous place of employment (name/city/state): **Veterans Affairs Nursing Home / Manteno / IL (Locum)**		
Title or professional occupation and clinical practice area(s): **Nurse Practitioner**	From: **05/2019**	To: **10/2019**
Last place of employment (name/city/state): **Hospital Care Group / Fort Wayne / IN**		
Title or professional occupation and clinical practice area(s): **Nurse Practitioner - Hospitalist**	From: **01/2018**	To: **04/2019**
Previous place of employment (name/city/state): **University of Chicago Hospitals / Chicago Heights / IL**		
Title or professional occupation and clinical practice area(s): **Registered Nurse**	From: **01/2014**	To: **01/2019**
Previous place of employment (name/city/state):		
Title or professional occupation and clinical practice area(s):	From:	To:
Last place of employment (name/city/state):		
Title or professional occupation and clinical practice area(s):	From:	To:
Previous place of employment (name/city/state):		
Title or professional occupation and clinical practice area(s):	From:	To:
Previous place of employment (name/city/state):		
Title or professional occupation and clinical practice area(s):	From:	To:

Why do you want to join the Lake County Health Department? (to be completed by new providers only)

I want to join the Lake County Health Department because I am passionate about improving the health and well-being of the community through prevention, education, and accessible healthcare services. With clinical experience and commitment to serving diverse populations, I hope to make a meaningful and impact by addressing public health needs, prompting health equity and helping individuals and families achieve better health outcomes.

Lake County Health Department and Community Health Center
3010 Grand Ave.
Waukegan, IL 60085
Phone: (847) 377-8098 Fax: (847) 984-5577

☑ **FQHC** ☑ **CMHC** ☑ **SUPR** ☐ **Prevention**

MEDICAL STAFF

CLINICAL DELINEATION OF PRIVILEGES FOR ADVANCED PRACTICE REGISTERED NURSE (APRN) OR CERTIFIED NURSE MIDWIFE (CNM)

☑ **Initial Appointment** ☐ **Reappointment** ☐ **Revision**
(you **must** select one)

Name (Last/First/Middle): Riggins / Michelle / Franshawn

Qualifications: Candidates must have an active license to practice as an Advanced Practice Nurse in Illinois and certification and/or recertification in the APRN specialty track.

Procedures: Successful completion of an accredited masters or doctoral program in the APRN specialty track and, recognized course when such exists, or acceptable supervised training in programs with accreditation, and demonstration of indications for the procedure/test/therapy, and doc umentation of competence to obtain and retain clinical privileges.

Reappointment Requirements: Current clinical competence.

Applicant: Place a check mark in the **R** column for each privilege requested.

Reviewer: Place a check mark in either the **A**, **C**, or **N** column for each privilege requested based on the following:
A = Recommended as Requested / **C** = Recommended w/ Conditions / **N** = Not Recommended

R	CORE PRIVILEGES	A	C	N
	Collaborative Practice			
✔	Full Practice Authority	✔		
	Provide Family Planning Services			
	Provide Prenatal Care			
✔	To evaluate, diagnose, consult, and treat pediatric patients from the age of 0-18 years	✔		
✔	To work-up, diagnose, and provide nonsurgical treatment, including consultation for patients 18 and above or in need of care to treat general medical problems.	✔		

R	PROCEDURES APRNs or CNMs with these privileges are expected to demonstrate both the skill to perform the procedure and ability to manage procedurally related complications. These privileges may include:	A	C	N
	Cryotherapy			
	Nexplanon insertion and removal			
	I & D of Abscess			
	Cauterization of umbilical granuloma			
	Other:			

The following is a list of **NEW** privileges with proof of competence attached:

1. _____

2. _____

3. _____

☐

The following is a list of privileges **DELETED** since the last application:

1. _____

2. _____

3. _____

☐

ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those specific clinical privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform and wish to exercise at Lake County Health Department and Community Health Center.

I understand that:

(a) In exercising any clinical privileges granted, I am constrained by any Lake County Health Department and Community Health Center policies and rules generally applicable and/or applicable to the particular situation.

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable Community Standards of Medical Care.

DocuSigned by:
47A1C5FGB4B7490...

6/3/2026

Applicant Signature | Date

SIGNATURE PAGE

Applicant Name: Michelle Riggins Privileges Effective: 7/22/2026 to 7/21/2028

Rationale for revision (if applicable):

Privileges indicated are approved with the exception of the following:

Consultation required on the following:

Documentation regarding performance requested on the following:

I have reviewed credentialing information, peer reviews and supervisor confirmation and verified that the licensed independent practitioner named above is competent to perform the requested privileges and fit to perform the duties of the job in a safe, secure, and effective manner.

DocuSigned by:
Reddy, Daram
0F3784D8938344D...
6/15/2026 | 12:56 PM CDT
Reddy, Daram

Signature of Director of Provider Operations | Date | Printed Name

Signed by:
Nuha Shair
0623385E7164447...
6/30/2026 | 2:21 PM CDT
Nuha Shair

Signature of Medical Director | Date | Printed Name

Signature of Board of Health President | Date | Printed Name

Signature of Governing Council Chair | Date | Printed Name

Signature of Executive Director | Date | Printed Name

Lake County Health Department and Community Health Center
Provider Checklist
(To be completed by Medical Staff Office Specialist)

☒ **Reappointment 2026**

Provider Name: Sana Ahmed MD **Specialty: Internal Medicine**

☒ **FT** ☐ **PT** ☐ **FLEX** ☐ **Contracted**

☒ State of IL Recredentialing Application

☒ CV

☒ IL License / CDS / DEA

☒ Privileging Form

☒ Driver's License

☒ 2 Peer References

☒ CME / CEU Acknowledgement

☒ Board Certification(s)

☒ Release / Authorization Forms

☒ CPR Certification

☒ BOH Credentialing Committee Provider Summary Sheet

☒ Sex Offender Registry

☒ National Practitioner Data Bank (NPDB)
(Medical malpractice litigation)

☒ IL Dept of Finance & Prof. Regulation (IDFPR)
(Current licensure)

☒ Drug Enforcement Administration
(Diversion Control Division)

☒ Office of Inspector General (OIG)
(Convictions for program-related fraud, patient abuse, licensing board actions, health assistance loan default)

☒ American Medical Association (AMA) (MD/DO only)
(Med school graduation, residency training specialty, board certification)

Reviewed and Completion Confirmed by: Sandra Montejano 06/09/2026

Sandra Montejano, Medical Staff Office Specialist Date

BOARD OF HEALTH CREDENTIALING COMMITTEE & GOVERNING COUNCIL PERSONNEL COMMITTEE
PROVIDER INFORMATION SUMMARY
Doctor of Medicine (MD) and Doctor of Osteopathic Medicine (DO)

SECTION A: PROVIDER INFORMATION		
First Name: **Sana**	Middle Initial: **S**	Last Name: **Ahmed**
Degree/Title: **MD**		
Language(s) spoken: **Hindi, Urdu, Spanish**		
Specialty: **Internal Medicine**	Board Certified? Y ☒ N ☐	If **Y**, certifying board? **American Board of Internal Medicine**
If **N**, board eligible? Y ☐ N ☐		If **Y**, exam date: **2017** 2017
Subspecialty: **Infectious Disease**	Board Certified? Y ☒ N ☐	Certifying Board: **American Board of Internal Medicine**
LCHD Clinic Site(s): (this field to be completed by LCHD credentialing staff) **Tuberculosis Clinic / Belvidere Medical Building / Waukegan /IL**		

SECTION B: EDUCATION & TRAINING		
Medical School Name/City/State: **University of Illinois Chicago / Chicago / IL**		
Degree: **MD**	Year Graduated: **2009**	
International Medical Graduate? Yes: _____ If Yes, ECFMG certification date: _____ USMLE date: _____		
Internship Name /City/State: **Internal Medicine -Advocate Lutheran General Hospital / Park Ridge / IL**	From: **2009**	To: **2010**
Residency 1 Name/City/State: **Internal Medicine - Advocate Lutheran General Hospital / Park Ridge / IL**	From: **2010**	To: **2012**
Fellowship: Name/City/State: **Infectious Disease/Stanford Hospital & Clinics/Palo Alto/CA**	From: **2012**	To: **2014**

SECTION C: WORK HISTORY		
Last place of employment (name/city/state): **Lake County Health Department / Waukegan / IL**		
Title or professional occupation: **Medical Epidemiologist/Medical Advisor/Physician: TB Clinic and STI/MMC**	From: **03/2018**	To: **Present**
Previous place of employment (name/city/state): **Center for Disease Control and Prevention / Atlanta / Georgia**		
Title or professional occupation: **Epidemic Intelligence Service Officer**	From: **2015**	To: **2018**
Previous place of employment (name/city/state):		
Title or professional occupation:	From:	To:

Why do you want to join the Lake County Health Department? (to be completed by new providers only)

Lake County Health Department and Community Health Center
3010 Grand Ave.
Waukegan, IL 60085
Phone: (847) 377-8098 Fax: (847) 984-5577

[X] **FQHC** [ ] **CMHC** [ ] **SUPR** [X] **Prevention**

MEDICAL STAFF

CLINICAL DELINEATION OF PRIVILEGES FOR INTERNAL MEDICINE

[ ] **Initial Appointment** [X] **Reappointment** [ ] **Revision**
(you **must** select one)

Name (Last/First/Middle): Ahmed/Sana/Shireen

Qualifications: Candidates must have an active license to practice Medicine and Surgery in Illinois.Current certification or eligibility in the process leading to certification in general internal medicine by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine. Successful completion of an accredited ACGME or AOA residency program in internal medicine.

Procedures: Successful completion of an approved, recognized course when such exists, or acceptable supervised training in residency, fellowship to other acceptable programs, and demonstration of indications for the procedure/test/therapy, and documentation of competence to obtain and retain clinical privileges.

Reappointment Requirements: Current clinical competence.

Applicant: Place a check mark in the **R** column for each privilege requested.

Reviewer: Place a check mark in either the **A**, **C**, or **N** column for each privilege requested based on the following:
A = Recommended as Requested / **C** = Recommended w/ Conditions / **N** = Not Recommended

R	CORE PRIVILEGES	A	C	N
X	To work-up, diagnose, and provide nonsurgical treatment, including consultation for patients 18 and over or in need of care to treat general medical problems.	X		

R	PROCEDURES Physicians with these privileges are expected to demonstrate both the skill to perform the procedure and ability to manage procedurally related complications. These privileges may include:	A	C	N
X	Other: Wound debridement	X		
X	cryotherapy for wart removal	X		
X	Use of PH paper	X		
X	Provide TB/STI and public health threat testing and treatment to pediatric patients	X		
X	Write standing orders for LCHD clients/community for testing, treatment, and prevention	X		

☐ The following is a list of **NEW** privileges with proof of competence attached:

1. _____

2. _____

3. _____

☐ The following is a list of privileges **DELETED** since the last application:

1. _____

2. _____

3. _____

ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those specific clinical privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform and wish to exercise at Lake County Health Department and Community Health Center.

I understand that:

(a) In exercising any clinical privileges granted, I am constrained by any Lake County Health Department and Community Health Center policies and rules generally applicable and/or applicable to the particular situation.

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable Community Standards of Medical Care.

Sana Ahmed 6/3/2026

Applicant Signature Date

SIGNATURE PAGE

Applicant Name: Sana Ahmed MD Privileges Effective: 7/22/26 to 07/21/28

Rationale for revision (if applicable):

Privileges indicated are approved with the exception of the following:

Consultation required on the following:

Documentation regarding performance requested on the following:

I have reviewed credentialing information, peer reviews and supervisor confirmation and verified that the licensed independent practitioner named above is competent to perform the requested privileges and fit to perform the duties of the job in a safe, secure, and effective manner.

Signed by: Nuha Shair Signature of Medical Director	7/2/2026 | 2:31 PM CDT Date	Nuha Shair Printed Name
Signature of Board of Health President	Date	Printed Name
Signature of Governing Council Chair	Date	Printed Name
Signature of Executive Director	Date	Printed Name

Lake County Health Department and Community Health Center
Provider Checklist
(To be completed by Medical Staff Office Specialist)

☒ **Reappointment 2026**

Provider Name: Jennifer Gassman APRN **Specialty:** Family Nurse Practitioner

☐ **FT** ☐ **PT** ☒ **FLEX**

☒ State of IL Recredentialing Application

☒ CV

☒ IL License
RN / APRN / CDS / DEA

☒ Privileging Form

☒ Driver's License

☒ 2 Peer References

☒ CME / CEU Acknowledgement

☒ Board Certification / Recertification

☒ Release / Authorization Forms

☒ CPR Certification

☒ BOH Credentialing Committee Provider Summary Sheet

☒ Sex Offender Registry

☒ National Practitioner Data Bank (NPDB)
(Medical malpractice litigation)

☒ IL Dept of Finance & Prof. Regulation (IDFPR)
(Current licensure)

☒ Drug Enforcement Administration
(Diversion Control Division)

☒ Office of Inspector General (OIG)
(Convictions for program-related fraud, patient abuse, licensing board actions, health assistance loan default)

Reviewed and Completion Confirmed by: Sandra Montejano 6/5/2026

Sandra Montejano, Medical Staff Office Specialist Date

BOARD OF HEALTH CREDENTIALING COMMITTEE & GOVERNING COUNCIL PERSONNEL COMMITTEE
PROVIDER INFORMATION SUMMARY
Advanced Practice Registered Nurse (APRN)

SECTION A: PROVIDER INFORMATION		
First Name: **Jennifer**	Middle Initial:	Last Name: **Gassman**
Degree(s), License, and APRN Certification: **DNP, FPA- APRN, Family Nurse Practitioner**		
Language(s) spoken: **English**		
Name of certification examination: **Family Nurse Practitioner**		Certifying Body/Organization: **American Nurses Credentialing Center**
APRN Certification Start Date: **10/16/2024**		APRN Certification Expiration Date: **10/15/2029**
IL APRN License Number: **277000134** Expiration Date: **05/31/2028**		Full Practice Authority: Y ☒ N ☐ If N: Name of LCHD Collaborating Physician:
IL RN License Number: **041275574** Expiration Date: **05/31/2028**		
LCHD Clinic Site(s): (this field to be completed by LCHD credentialing staff) **HD-BH- ATP- (Addiction Treatment Program) Flex / FQHC Flex to LCHD Clinic Sites**		

SECTION B: EDUCATION & TRAINING	
APRN Accredited Academic Institution Attended: School Name/City/State: **North Park University / Chicago / IL**	
Degree: **DNP**	Year Graduated: **2014**
New APRN graduate: List of the dominant areas of clinical focus during your APRN training:	
Experienced APRN: List of the dominant areas of APRN Practice and Expertise: **progressive clinical experience delivering comprehensive primary, preventive, and acute care across public health, FQHC, retail, and acute care settings**	
Academic degree(s): Check or list any other academic degrees that you have earned: BSN: _X_____ MSN: _X_____ DNP: _X_____ PhD: ____ Other: _____	
Degree/Name of School/City/State of each of the above that are checked: **DNP: Doctor of Nursing / Northern Kentucky University**	
MSN: Master of Science in Nursing / North Park University / North Park / IL	
BSN: Bachelor of Science in Nursing / University of Illinois / Chicago / IL	
Year of initial RN licensure: **1993**	Years practicing as RN (before APRN): **11 yrs**
RN Experience: List of your dominant areas of RN practice and expertise: **ED, L&D, cardiac staff RN, Clinical Education**	

SECTION C: WORK HISTORY		
Last place of employment (name/city/state): **Lake County Health Department / Waukegan / IL**		
Title or professional occupation and clinical practice area(s): **Nurse Practitioner**	From: **2014**	To: **Present**
Previous place of employment (name/city/state): **CVS/Caremark/Vernon Hills/IL**		
Title or professional occupation and clinical practice area(s): **Family Nurse Practitioner**	From: **2016**	To: **2019**
Previous place of employment (name/city/state): **NM Hospital/Chicago/IL**		
Title or professional occupation and clinical practice area(s): **Staff RN: ED, L&D, Cardiac and Clinical Education**	From: **1994**	To: **2015**
Last place of employment (name/city/state):		
Title or professional occupation and clinical practice area(s):	From:	To:
Previous place of employment (name/city/state):		
Title or professional occupation and clinical practice area(s):	From:	To:
Previous place of employment (name/city/state):		
Title or professional occupation and clinical practice area(s):	From:	To:
Last place of employment (name/city/state):		
Title or professional occupation and clinical practice area(s):	From:	To:
Previous place of employment (name/city/state):		
Title or professional occupation and clinical practice area(s):	From:	To:
Previous place of employment (name/city/state):		
Title or professional occupation and clinical practice area(s):	From:	To:

Why do you want to join the Lake County Health Department? (to be completed by new providers only)

Lake County Health Department and Community Health Center
3010 Grand Ave.
Waukegan, IL 60085
Phone: (847) 377-8098 Fax: (847) 984-5577

☑ **FQHC** ☑ **CMHC** ☑ **SUPR** ☐ **Prevention**

MEDICAL STAFF

CLINICAL DELINEATION OF PRIVILEGES FOR ADVANCED PRACTICE REGISTERED NURSE (APRN) OR CERTIFIED NURSE MIDWIFE (CNM)

☐ **Initial Appointment** ☑ **Reappointment** ☐ **Revision**
(you **must** select one)

Name (Last/First/Middle): Gassman/Jennifer/Anne

Qualifications: Candidates must have an active license to practice as an Advanced Practice Nurse in Illinois and certification and/or recertification in the APRN specialty track.

Procedures: Successful completion of an accredited masters or doctoral program in the APRN specialty track and, recognized course when such exists, or acceptable supervised training in programs with accreditation, and demonstration of indications for the procedure/test/therapy, and doc umentation of competence to obtain and retain clinical privileges.

Reappointment Requirements: Current clinical competence.

Applicant: Place a check mark in the **R** column for each privilege requested.

Reviewer: Place a check mark in either the **A**, **C**, or **N** column for each privilege requested based on the following:
A = Recommended as Requested / **C** = Recommended w/ Conditions / **N** = Not Recommended

R	CORE PRIVILEGES	A	C	N
	Collaborative Practice			
x	Full Practice Authority	x		
x	Provide Family Planning Services	x		
	Provide Prenatal Care			
x	To evaluate, diagnose, consult, and treat pediatric patients from the age of 0-18 years	x		
x	To work-up, diagnose, and provide nonsurgical treatment, including consultation for patients 18 and above or in need of care to treat general medical problems.	x		

R	PROCEDURES APRNs or CNMs with these privileges are expected to demonstrate both the skill to perform the procedure and ability to manage procedurally related complications. These privileges may include:	A	C	N
	Cryotherapy			
	Nexplanon insertion and removal			
	I & D of Abscess			
x	Cauterization of umbilical granuloma	x		
	Other:			

The following is a list of **NEW** privileges with proof of competence attached:

1. _____

2. _____

3. _____

☐

The following is a list of privileges **DELETED** since the last application:

1. _____

2. _____

3. _____

☐

ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those specific clinical privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform and wish to exercise at Lake County Health Department and Community Health Center.

I understand that:

(a) In exercising any clinical privileges granted, I am constrained by any Lake County Health Department and Community Health Center policies and rules generally applicable and/or applicable to the particular situation.

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable Community Standards of Medical Care.

Gassman, Jennifer Digitally signed by Gassman, Jennifer Date: 2026.05.17 22:23:37 -05'00' 05/17/26

Applicant Signature Date

SIGNATURE PAGE

Applicant Name: Jennifer Gassman Privileges Effective: 7/22/2026 to 7/21/2028

Rationale for revision (if applicable):

Privileges indicated are approved with the exception of the following:

Consultation required on the following:

Documentation regarding performance requested on the following:

I have reviewed credentialing information, peer reviews and supervisor confirmation and verified that the licensed independent practitioner named above is competent to perform the requested privileges and fit to perform the duties of the job in a safe, secure, and effective manner.

Signed by: Toni Steres 5A10EAFBFDD2C4E3... 5/29/2026 | 8:30 AM CDT Toni Steres

Signature of Director of Provider Operations | Date | Printed Name

Signed by: Nuha Shair 0622385E7184447... 7/2/2026 | 12:36 PM CDT Nuha Shair

Signature of Medical Director | Date | Printed Name

Signature of Board of Health President | Date | Printed Name

Signature of Governing Council Chair | Date | Printed Name

Signature of Executive Director | Date | Printed Name

Lake County Health Department and Community Health Center
Provider Checklist
(To be completed by Medical Staff Office Specialist)

☒ **Reappointment 2026**

Provider Name: Jupa James MD **Specialty:** Internal Medicine and Infectious Disease

☐ **FT** ☐ **PT** ☒ **FLEX** ☐ **Contracted**

☒ State of IL Recredentialing Application

☒ CV

☒ IL License / CDS / DEA

☒ Privileging Form

☒ Driver's License

☒ 2 Peer References

☒ CME / CEU Acknowledgement

☒ Board Certification(s)

☒ Release / Authorization Forms

☒ CPR Certification

☒ BOH Credentialing Committee Provider Summary Sheet

☒ Sex Offender Registry

☒ National Practitioner Data Bank (NPDB)
(Medical malpractice litigation)

☒ IL Dept of Finance & Prof. Regulation (IDFPR)
(Current licensure)

☒ Drug Enforcement Administration
(Diversion Control Division)

☒ Office of Inspector General (OIG)
(Convictions for program-related fraud, patient abuse, licensing board actions, health assistance loan default)

☒ American Medical Association (AMA) (MD/DO only)
(Med school graduation, residency training specialty, board certification)

Reviewed and Completion Confirmed by: Sandra Montejano 06/09/2026

Sandra Montejano, Medical Staff Office Specialist Date

BOARD OF HEALTH CREDENTIALING COMMITTEE & GOVERNING COUNCIL PERSONNEL COMMITTEE
PROVIDER INFORMATION SUMMARY
Doctor of Medicine (MD) and Doctor of Osteopathic Medicine (DO)

SECTION A: PROVIDER INFORMATION		
First Name: Jupa	Middle Initial:	Last Name: James
Degree/Title: M.D.		
Language(s) spoken: English / Spanish		
Specialty: Internal Medicine	Board Certified? Y ☒ N ☐	If **Y**, certifying board? American Board of Internal Medicine
If **N**, board eligible? Y ☐ N ☐		If **Y**, exam date: **1972**
Subspecialty: Infectious Diseases	Board Certified? Y ☒ N ☐	Certifying Board: American Board of Internal Medicine
LCHD Clinic Site(s): (this field to be completed by LCHD credentialing staff) HD-PS-Tuberculosis Clinic – (Flex) Waukegan / IL		

SECTION B: EDUCATION & TRAINING		
Medical School Name/City/State: University of Illinois College of Medicine / Chicago / IL		
Degree: M.D.	Year Graduated: 1967	
International Medical Graduate? Yes: _____ If Yes, ECFMG certification date: _____ USMLE date: _____		
Internship Name /City/State:	From:	To:
Residency 1 Name/City/State: Rush Presbyterian St Luke's Medical Center / Chicago / IL	From: 1967	To: 1970
Residency 2 Name/City/State:	From:	To:

SECTION C: WORK HISTORY		
Last place of employment (name/city/state): Lake County Health Department - Tuberculosis Clinic / Waukegan / IL		
Title or professional occupation: Flex Physician	From: 2018	To: Present
Previous place of employment (name/city/state): Lake County Health Department - Board of Health / Waukegan / IL		
Title or professional occupation: Medical Advisor	From: 1992	To: 2018
Previous place of employment (name/city/state): Deerpath Medical Associates / Lake Bluff / IL		
Title or professional occupation: Staff Physician	From: 1992	To: 2001

Why do you want to join the Lake County Health Department? (to be completed by new providers only)

Lake County Health Department and Community Health Center
3010 Grand Ave.
Waukegan, IL 60085
Phone: (847) 377-8098 Fax: (847) 984-5577

☐ FQHC ☐ CMHC ☐ SUPR ☒ Prevention

MEDICAL STAFF

CLINICAL DELINEATION OF PRIVILEGES FOR INTERNAL MEDICINE

☐ Initial Appointment ☒ Reappointment ☐ Revision
(you **must** select one)

Name (Last/First/Middle): THAPA, JAMES, E.

Qualifications: Candidates must have an active license to practice Medicine and Surgery in Illinois.Current certification or eligibility in the process leading to certification in general internal medicine by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine. Successful completion of an accredited ACGME or AOA residency program in internal medicine.

Procedures: Successful completion of an approved, recognized course when such exists, or acceptable supervised training in residency, fellowship to other acceptable programs, and demonstration of indications for the procedure/test/therapy, and documentation of competence to obtain and retain clinical privileges.

Reappointment Requirements: Current clinical competence.

Applicant: Place a check mark in the **R** column for each privilege requested.

Reviewer: Place a check mark in either the **A**, **C**, or **N** column for each privilege requested based on the following:
A = Recommended as Requested / **C** = Recommended w/ Conditions / **N** = Not Recommended

R	CORE PRIVILEGES	A	C	N
X	To work-up, diagnose, and provide nonsurgical treatment, including consultation for patients 18 and over or in need of care to treat general medical problems.	X		

R	PROCEDURES Physicians with these privileges are expected to demonstrate both the skill to perform the procedure and ability to manage procedurally related complications. These privileges may include:	A	C	N
	Other:			

☐ The following is a list of **NEW** privileges with proof of competence attached:

1. NONE
2. _____
3. _____

☐ The following is a list of privileges **DELETED** since the last application:

1. NONE
2. _____
3. _____

ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those specific clinical privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform and wish to exercise at Lake County Health Department and Community Health Center.

I understand that:

(a) In exercising any clinical privileges granted, I am constrained by any Lake County Health Department and Community Health Center policies and rules generally applicable and/or applicable to the particular situation.

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable Community Standards of Medical Care.

Applicant Signature

20 MAY 2026
Date

SIGNATURE PAGE

Applicant Name: Jupa James Privileges Effective: 7/22/2026 to 7/21/2028

Rationale for revision (if applicable):

Privileges indicated are approved with the exception of the following:

Consultation required on the following:

Documentation regarding performance requested on the following:

I have reviewed credentialing information, peer reviews and supervisor confirmation and verified that the licensed independent practitioner named above is competent to perform the requested privileges and fit to perform the duties of the job in a safe, secure, and effective manner.

Signed by: Carmne Macias Huerta 7B9E42EA6AA445E... 6/9/2026 | 12:06 PM CDT Carmen Macias Huerta MD

Signature of Director of Provider Operations | Date | Printed Name

Signed by: Nuha Shair Signature of Medical Director 7/1/2026 | 3:56 PM CDT Nuha Shair

Signature of Medical Director | Date | Printed Name

Signature of Board of Health President | Date | Printed Name

Signature of Governing Council Chair | Date | Printed Name

Signature of Executive Director | Date | Printed Name

Lake County Health Department and Community Health Center
Provider Checklist
(To be completed by Medical Staff Office Specialist)

☒ **Reappointment 2026**

Provider Name: Anatoliy Pyslar MD **Specialty:** Psychiatry

☒ **FT** ☐ **PT** ☐ **FLEX** ☐ **Contracted**

☒ State of IL Recredentialing Application

☒ CV

☒ IL License / CDS / DEA

☒ Privileging Form

☒ Driver's License

☒ 2 Peer References

☒ CME / CEU Acknowledgement

☒ Board Certification(s)

☒ Release / Authorization Forms

☒ CPR Certification

☒ BOH Credentialing Committee Provider Summary Sheet

☒ Sex Offender Registry

☒ National Practitioner Data Bank (NPDB)
(Medical malpractice litigation)

☒ IL Dept of Finance & Prof. Regulation (IDFPR)
(Current licensure)

☒ Drug Enforcement Administration
(Diversion Control Division)

☒ Office of Inspector General (OIG)
(Convictions for program-related fraud, patient abuse, licensing board actions, health assistance loan default)

☒ American Medical Association (AMA) (MD/DO only)
(Med school graduation, residency training specialty, board certification)

Reviewed and Completion Confirmed by: Sandra Montejano 06/4/2026

Sandra Montejano, Medical Staff Office Specialist Date

BOARD OF HEALTH CREDENTIALING COMMITTEE & GOVERNING COUNCIL PERSONNEL COMMITTEE
PROVIDER INFORMATION SUMMARY
Doctor of Medicine (MD) and Doctor of Osteopathic Medicine (DO)

SECTION A: PROVIDER INFORMATION		
First Name: **Anatoliy**	Middle Initial:	Last Name: **Pyslar**
Degree/Title: **MD**		
Language(s) spoken: **English, Ukrainian**		
Specialty: **Psychiatry**	Board Certified? Y ☒ N ☐	If **Y**, certifying board? **American Board of Psychiatry and Neurology**
If **N**, board eligible? Y ☐ N ☐		If **Y**, exam date: **2014**
Subspecialty:	Board Certified? Y ☐ N ☐	Certifying Board:
LCHD Clinic Site(s): (this field to be completed by LCHD credentialing staff) **HD-BH-OPMH-GRAND**		

SECTION B: EDUCATION & TRAINING		
Medical School Name/City/State: **Bukovinian State Medical University / Chernivtsi / Ukraine**		
Degree: **MD**	Year Graduated: **2003**	
International Medical Graduate? Yes: **X** If Yes, ECFMG certification date: **2009** USMLE date: **2009**		
Internship Name /City/State: **MetroHealth Medical Center /Cleveland / Ohio**	From: **2010**	To: **2011**
Residency 1 Name/City/State: **MetroHealth Medical Center / Cleveland / Ohio**	From: **2011**	To: **2012**
Residency 2 Name/City/State: **RFU / North Chicago / IL**	From: **2012**	To: **2014**

SECTION C: WORK HISTORY		
Last place of employment (name/city/state): **Lake County Health Dpt / Waukegan / IL**		
Title or professional occupation: **Psychiatrist**	From: **2014**	To: **Present**
Previous place of employment (name/city/state): **Chicago Read Hospital / Chicago / IL**		
Title or professional occupation: **Psychiatrist**	From: **2018**	To: **2021**
Previous place of employment (name/city/state):		
Title or professional occupation:	From:	To:

Why do you want to join the Lake County Health Department? (to be completed by new providers only)

Lake County Health Department and Community Health Center
3010 Grand Avenue
Waukegan, IL 60085
Phone: (847) 377-8098 Fax: (847) 984-5577

☑ **FQHC** ☑ **CMHC** ☐ **SUPR** ☐ **Prevention**

MEDICAL STAFF

CLINICAL DELINEATION OF PRIVILEGES FOR PSYCHIATRY

☐ **Initial Appointment** ☑ **Reappointment** ☐ **Revision**
(you **must** select one)

Name (Last/First/Middle): Pyslar/Anatoliy

Qualifications: All candidates must have an active license to practice Medicine and Surgery in Illinois.

General Psychiatry: Criteria for requesting general privileges in Psychiatry are successful completion of an American College of Graduate Medical Education or American Osteopathic Association (ACGME/AOA) accredited residency program in Psychiatry or enrollment and good standing in an accredited residency program in Psychiatry.

Also required is current initial certification or in the process leading to initial certification in Psychiatry by the American Board of Psychiatry and Neurology (ABPN) or the American Osteopathic Board of Neurology and Psychiatry (AOBNP).

Child Psychiatry: Criteria for requesting child and adolescent privileges in Psychiatry are successful completion of at least three years of an ACGME/AOA accredited residency program in Psychiatry and completion of an ACGME/AOA accredited fellowship program in Child and Adolescent Psychiatry.

Also required is current initial certification or in the process leading to initial certification in Psychiatry by the ABPN or AOBNP, and current initial subspecialty certification or active participation in the process leading to initial certification in Child and Adolescent Psychiatry by the ABPN or AOBNP.

Addiction Psychiatry: Criteria for requesting privileges in addiction psychiatry are successful completion of an ACGME/AOA accredited residency program in Psychiatry, with at least one additional year of full-time equivalent training in an ACGME/AOA accredited fellowship in Addiction Psychiatry, or sufficient cumulative working experience in Addiction Psychiatry as determined by the Behavioral Health Medical Director.

Also required is current initial certification or in the process leading to initial certification in Psychiatry by the ABPN or the AOBNP, with or without current initial subspecialty certification or active participation in the process leading to initial certification in Addiction Psychiatry or Addiction Medicine by the ABPN or AOA Addiction Medicine Examination Committee.

Procedures: Successful completion of an approved, recognized course when such exists, or acceptable supervised training in residency, fellowship or other acceptable programs, and demonstration of indications for the procedure/test/therapy, and documentation of competence to obtain and retain clinical privileges.

Reappointment Requirements: Current clinical competence.

Applicant: Place a check mark in the **R** column for each privilege requested.

Reviewer: Place a check mark in either the **A**, **C**, or **N** column for each privilege requested based on the following:
A = Recommended as Requested / **C** = Recommended w/ Conditions / **N** = Not Recommended

R	GENERAL PSYCHIATRY CORE PRIVILEGES	A	C	N
✔	Admission, work-up, diagnosis and treatment of adult patients over 15 years of age who suffer from mental, behavioral, or emotional disorders. Privileges include providing evaluation and management services, patient and family counseling and education, and individual psychotherapy with or without evaluation and management. Privileges also include providing consultation with clinicians in other fields regarding mental, behavioral, or emotional disorders, and psychopharmacotherapy. Core privileges do not include privileges in ECT.	✔		

R	CHILD & ADOLESCENT GENERAL PSYCHIATRY CORE PRIVILEGES	A	C	N
	Admission, work-up, diagnosis and treatment of children and adolescents (age 21 and under) who suffer from mental, behavioral, or emotional disorders. Privileges include providing evaluation and management services, patient and family counseling and education, and individual psychotherapy with or without evaluation and management. Privileges also include providing consultation with clinicians in other fields regarding mental, behavioral, or emotional disorders, and psychopharmacotherapy. Core privileges do not include privileges in ECT.			

R	ADDICTION PSYCHIATRY CORE PRIVILEGES	A	C	N
	Admission, work-up, diagnosis and treatment of patients of any age with problems related to alcoholism and other drug dependencies and addictions. Privileges include providing medication assisted treatment (MAT), evaluation and management services, patient and family counseling and education, and all forms of psychological and social treatment. Privileges also include providing consultation with clinicians in other fields regarding addictive disorders and MAT.			

R	MAT PROCEDURES Successful completion of an approved, recognized course when such exists, or acceptable supervised training in residency, fellowship or other acceptable program, and demonstration of indications for the procedure/test/therapy, and documentation of competence to obtain and retain clinical privileges. Specifically, for the following: **Medication Assisted Therapy (MAT) for opioid dependence with buprenorphine-containing products**:	A	C	N
	MAT for opioid dependence with buprenorphine-containing products			
	MAT for opioid use disorder with Methadone			

Group Psychotherapy: Completion of at least one year of ACGME/AOA accredited residency training in General Psychiatry in which group psychotherapy was required and practiced under supervision.

Family Psychotherapy: Completion of at least one year of ACGME/AOA accredited residency training in General Psychiatry or fellowship program in Child and Adolescent Psychiatry in which family psychotherapy was required and practiced under supervision.

Behavior Modification: Completion of one year of approved verifiable graduate training in a program which is approved by the American Psychiatric Association and/or American Psychological Association in which the modality was specifically taught and/or must be supervised by a fully licensed psychologist or psychiatrist independently privileged in this area.

R	SPECIAL PROCEDURES	A	C	N
	Group Psychotherapy			
	Family Psychotherapy			
	Behavior Modification			
	Other:			
	Other:			
	Other:			

☐ **The following is a list of NEW privileges with proof of competence attached:**

1. _____
2. _____
3. _____

☐ **The following is a list of privileges DELETED since the last application:**

1. _____
2. _____
3. _____

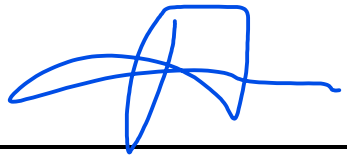
ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those specific clinical privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform and wish to exercise at Lake County Health Department and Community Health Center.

I understand that:

(a) In exercising any clinical privileges granted, I am constrained by any Lake County Health Department and Community Health Center policies and rules generally applicable and/or applicable to the particular situation.

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable Community Standards of Medical Care.



05/28/26

Applicant Signature Date:

SIGNATURE PAGE

Applicant Name: Anatoily Pyslar Privileges Effective: 7/22/2026 to 7/21/2028

Rationale for revision (if applicable):

Privileges indicated are approved with the exception of the following:

Consultation required on the following:

Documentation regarding performance requested on the following:

I have reviewed credentialing information, peer reviews and supervisor confirmation and verified that the licensed independent practitioner named above is competent to perform the requested privileges and fit to perform the duties of the job in a safe, secure, and effective manner.

DocuSigned by:
Reddy, Daram
DE3784D8938344D...

Signature of Medical Director of Provider Operations	Date	Printed Name
	6/5/2026 | 11:11 AM CDT	Reddy, Daram

Signed by:
Nuha Shair
D022282E7164447...

Signature of Medical Director	Date	Printed Name
	7/6/2026	Nuha Shair

Signature of Board of Health President	Date	Printed Name

Signature of Governing Council Chair	Date	Printed Name

Signature of Executive Director	Date	Printed Name