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: Shaman Bhullar MD **Specialty: Psychiatry- Resident**

☐ FT **☐ PT** **☐ FLEX** **☒ CONTINGENT**

☒ 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)

Reviewed and Completion Confirmed by: Sandra Montejano 5/4/2026

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: **Shaman**	Middle Initial:	Last Name: **Bhullar**
Degree/Title: **Doctor of Medicine (M.D.)**		
Language(s) spoken: **English**		
Specialty: **Psychiatry**	Board Certified? Y ☐ N ☒	If **Y**, certifying board?
If **N**, board eligible? Y ☐ N ☒		If **Y**, exam date:
Subspecialty:	Board Certified? Y ☐ N ☐	Certifying Board:
LCHD Clinic Site(s): (this field to be completed by LCHD credentialing staff) **OPMH - Grand**		

SECTION B: EDUCATION & TRAINING		
Medical School Name/City/State: **Yale School of Medicine / New Haven / Connecticut**		
Degree: **Doctor of Medicine (M.D.)**	Year Graduated: **2023**	
International Medical Graduate? Yes: _____ If Yes, ECFMG certification date: _____ USMLE date: _____		
Internship Name /City/State:	From:	To:
Residency 1 Name/City/State: **Rosalind Franklin University / North Chicago IL**	From: **2023**	To: **Present**
Residency 2 Name/City/State:	From:	To:

SECTION C: WORK HISTORY		
Last place of employment (name/city/state): **N/A (in training)**		
Title or professional occupation:	From:	To:
Previous place of employment (name/city/state):		
Title or professional occupation:	From:	To:
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)

For residency training to better understand and manage patients in an outpatient psych setting.

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): Bhullar / Shaman

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:			

[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.

Signed by:
Shaman Bhullar
D9A8D4F146E340E...

4/2/26

Applicant Signature Date:

SIGNATURE PAGE

Applicant Name: Shaman Bhullar Privileges Effective: 5/27/2026 to 5/26/2028

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: Anatoliy Pyslar 5/1/2026 | 9:24 AM CDT Anatoliy Pyslar

Signature of Medical Director of Provider Operations | Date | Printed Name

Signed by: Nuha Shair 5/14/2026 | 8:38 AM 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)

☒ Initial Appointment and Privileging 2026

Provider Name: Ali Mahmoud MD Specialty: Psychiatry - Resident

☐ FT ☐ PT ☐ FLEX ☒CONTINGENT

☒ 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)

Reviewed and Completion Confirmed by: Sandra Montejano 5/11/2026

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: **Ali**	Middle Initial:	Last Name: **Mahmoud**
Degree/Title: **Doctor of Medicine (M.D.)**		
Language(s) spoken: **English**		
Specialty: **Psychiatry**	Board Certified? **Y ☐ N ☒**	If **Y**, certifying board?
If **N**, board eligible? **Y ☐ N ☒**		If **Y**, exam date:
Subspecialty:	Board Certified? **Y ☐ N ☐**	Certifying Board:
LCHD Clinic Site(s): (this field to be completed by LCHD credentialing staff) **OPMH Grand**		

SECTION B: EDUCATION & TRAINING		
Medical School Name/City/State: Northwestern **Feinberg School of Medicine / Chicago / IL**		
Degree: **MD**	Year Graduated: **2024**	
International Medical Graduate? Yes: _____ If Yes, ECFMG certification date: _____ USMLE date: _____		
Internship Name /City/State:	From:	To:
Residency 1 Name/City/State: **Chicago Medical School / North Chicago / IL**	From: **05/2024**	To: **Present**
Residency 2 Name/City/State:	From:	To:

SECTION C: WORK HISTORY		
Last place of employment (name/city/state): **N/A**		
Title of professional occupation:	From:	To:
Previous place of employment (name/city/state):		
Title or professional occupation:	From:	To:
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)

Fulfill duties as a resident.

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): Mahmoud / Ali

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:			

[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.

Signed by:
Ali Mahmoud
06B5F4EFC38B434...

3/19/2026

Applicant Signature Date:

SIGNATURE PAGE

Applicant Name: Ali Mahmoud Privileges Effective: 5/27/2026 to 5/26/2028

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: Anatoliy Pyslar
F9F54385BB2B4BD...
5/1/2026 | 9:25 AM CDT
Signature of Medical Director of Provider Operations | Date | Anatoliy Pyslar — Printed Name

Signed by: Nuha Shair
0622385E7464447...
5/14/2026 | 10:48 AM CDT
Signature of Medical Director | 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: Stephanie Moss MD Specialty: Psychiatry - Resident

☐ FT **☐ PT** **☐ FLEX** **☒CONTINGENT**

☒ 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)

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

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: **Stephanie**	Middle Initial:	Last Name: **Moss**
Degree/Title: **Doctor of Medicine (M.D.)/Psychiatry Resident**		
Language(s) spoken: **English & Spanish**		
Specialty: **Psychiatry**	Board Certified? **Y ☐ N ☒**	If **Y**, certifying board?
If **N**, board eligible? **Y ☐ N ☒**		If **Y**, exam date: **2028**
Subspecialty:	Board Certified? **Y ☐ N ☐**	Certifying Board:
LCHD Clinic Site(s): (this field to be completed by LCHD credentialing staff) **OPMH Grand**		

SECTION B: EDUCATION & TRAINING		
Medical School Name/City/State: **Rush University / Chicago / IL**		
Degree: **Doctor of Medicine (M.D.)**	Year Graduated: 2024	
International Medical Graduate? Yes: _____ If Yes, ECFMG certification date: _____ USMLE date: _____		
Internship Name /City/State:	From:	To:
Residency 1 Name/City/State: **Rosalind Franklin University / North Chicago / IL**	From: **2024**	To: **2028**
Residency 2 Name/City/State:	From:	To:

SECTION C: WORK HISTORY		
Last place of employment (name/city/state): **None as a MD**		
Title or professional occupation:	From:	To:
Previous place of employment (name/city/state):		
Title or professional occupation:	From:	To:
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)

To be an out-patient Psychiatry resident to care for the lake county community in Spanish and English.

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): Stephanie Moss

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.

Signed by:
Stephanie Moss
6AED42AEBF6745A...

Applicant Signature

4/09/2026

Date:

SIGNATURE PAGE

Applicant Name: Stephanie Moss Privileges Effective: 5/27/2026 to 5/26/2028

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: Anatoliy Pyslar
E9D54386BB254BD...
5/1/2026 | 9:24 AM CDT

Signature of Medical Director of Provider Operations	Date	Printed Name
		Anatoliy Pyslar

Signed by: Nuha Shair
05223B5E7164447...
5/14/2026 | 10:52 AM CDT

Signature of Medical Director	Date	Printed Name
		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: Beth Richardson DPM Specialty: Podiatric Medicine

☐ **FT** ☐ **PT** ☒ **Contingent**

☒ 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)

Reviewed and Completion Confirmed by: Sandra Montejano 4/6/2026

Sandra Montejano, Medical Staff Office Specialist Date

BOARD OF HEALTH CREDENTIALING COMMITTEE & GOVERNING COUNCIL PERSONNEL COMMITTEE
PROVIDER INFORMATION SUMMARY

SECTION A: PROVIDER INFORMATION		
First Name: Beth	Middle Initial: **B**	Last Name: Richardson
Degree/Title: Doctor of Podiatric Medicine/Podiatrist		
Language(s) spoken: English		
Specialty: Podiatry	Board Certified? **Y** ☒ **N** ☐	If **Y**, certifying board? American Board of Podiatric Medicine
If **N**, board eligible? **Y** ☒ **N** ☐		If **Y**, exam date: 10/2022
Subspecialty:	Board Certified? **Y** ☐ **N**☐	Certifying Board:
LCHD Clinic Site(s): (this field to be completed by LCHD credentialing staff) HD-PH-MEDICAL-GRAND		

SECTION B: EDUCATION & TRAINING		
Medical School Name/City/State: Dr. William M Scholl College of Podiatric Medicine at Rosalind Franklin University / North Chicago / IL		
Degree: Doctor of Podiatric Medicine / DPM	Year Graduated: 2020	
International Medical Graduate? Yes: _____ If Yes, ECFMG certification date: _____ USMLE date: _____		
Internship Name /City/State:	From:	To:
Residency 1 Name/City/State: OSF St Katharine Medical Center (formerly Katherine Shaw Bethea Hospital) Dixon, IL	From: 06/2020	To: 06/2023
Residency 2 Name/City/State:	From:	To:

SECTION C: WORK HISTORY		
Last place of employment (name/city/state): Dr. William M Scholl College of Podiatric Medicine at Rosalind Franklin University of Medicine & Science / North Chicago / IL		
Title or professional occupation: Assistant Professor	From: 11/2025	To: Present
Previous place of employment (name/city/state): UW Health SwedishAmerican Hospital		
Title or professional occupation: Podiatrist	From: 08/2023	To: 06/2025
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 looking to join the Lake County Health Department to support both patient care and clinical education in an underserved population. As an assistant professor, my primary goal is to integrate high-quality, evidence-based lower extremity care with hands-on student training in a community-focused setting.

County health systems play a critical role in providing access to care for vulnerable and medically complex patients. Practicing within this environment allows me to contribute meaningfully to reducing disparities in lower extremity health, particularly in the prevention and management of limb-threatening conditions.

Equally important, this setting provides an invaluable educational experience for students. Exposure to a diverse patient population with advanced pathology helps trainees develop clinical judgment, cultural competence, and an appreciation for multidisciplinary, resource-conscious care. My intention is to create a structured, supervised learning environment that emphasizes both clinical excellence and compassionate service.

By joining the Lake County Health Department, I hope to contribute to its mission of accessible, high-quality care while preparing the next generation of podiatric physicians to serve communities in need.

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 PODIATRY

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

Name (Last/First/Middle): Richardson / Beth

Qualifications: Board Eligibility, Qualification, or Certification within specialty. If not Board Certified, ability to become so within 7 years of completion of residency

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	CORE PRIVILEGES	A	C	N
X	Work up, diagnose, and provide treatment including consultation for patients (adults and children) in need of podiatric care.	X		
X	Taking and interpreting foot/ankle radiographs.	X		

R	PROCEDURES	A	C	N
X	Bone biopsy - open wounds only	X		
X	Casting for orthoses	X		
X	Casting/splinting for traumatic/non-traumatic disorders	X		
X	Foreign body removal with/without local anesthesia	X		
X	Fracture reductions under local anesthesia	X		
X	Hardware removal under local anesthesia	X		
X	Injections - therapeutic and diagnostic with/without steroid	X		
X	Nail Avulsions / Matricectomy - Permanent or Temporary	X		
X	Nail Biopsy	X		
X	Skin biopsy - sharp / punch / shave	X		
X	Wart excision / cautery	X		
X	Wound care treatments:debridement, modality application	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 Podiatry Care.

Signed by:
45D4C220417AB42B...

03/23/2026

Applicant Signature

Date:

SIGNATURE PAGE

Applicant Name: Beth B Richardson Privileges Effective: 4/22/2026 to 4/21/2028

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:

3/24/2026 | 7:30 PM CDT STEPHANIE WU

Signature of Dean Date Printed Name
Dr William M Scholl College of Podiatric Medicine at
Rosalind Franklin University of Medicine and Science

Signed by:
Nuha Shair

4/7/2026 | 12:52 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: Irina Bolotnikova DDS **Specialty: Dentist**

☐ **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

☒ 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 2/10/2026

Sandra Montejano, Medical Staff Office Specialist Date

BOARD OF HEALTH CREDENTIALING COMMITTEE & GOVERNING COUNCIL PERSONNEL COMMITTEE
PROVIDER INFORMATION SUMMARY
Dentist: Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD)

SECTION A: PROVIDER INFORMATION		
First Name: Irina	Middle Initial:	Last Name: Bolotnikova
Degree/Title: Doctor of Dentistry/ DDS		
Language(s) spoken: English / Russian		
Specialty: General Dentist		
LCHD Clinic Site(s): (this field to be completed by LCHD credentialing staff) HD-PH-DENTAL-BMB		

SECTION B: EDUCATION & TRAINING		
Medical/Professional School Name/City/State: State of Belarus Medical Institute/Minsk/Belarus from 09/84 to 06/89		
Degree: Doctor of Dentistry / DDS	Year Graduated: 1998	
International School, must attend accredited US Dental School Advanced Studies Program: Name/City/State University of Illinois Chicago College of Dentistry / Chicago / IL	From: 09/96	To: 06/98
Internship Name /City/State:	From:	To:
Residency 1 Name/City/State:	From:	To:
Residency 2 Name/City/State:	From:	To:

SECTION C: WORK HISTORY		
Last place of employment (name/city/state): Lake County Health Department / Waukegan / IL		
Title or professional occupation: Dentist	From: 1998	To: Present
Previous place of employment (name/city/state): General Dentist /Morton Grove / IL		
Title or professional occupation: self employed	From: 2000	To: Present
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

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

MEDICAL STAFF

CLINICAL DELINEATION OF PRIVILEGES FOR DENTAL MEDICINE

☐ **Initial Appointment** ☑ **Reappointment** ☐ **Revision**

(you **must** select one)

Name (Last/First/Middle): Bolotnikova, Irina

Qualifications: Candidates must have an active license to practice Dentistry in Illinois. Completion of an ADA-accredited program in dentistry or foreign equivalent.

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	CORE PRIVILEGES	A	C	N
✔	Core privileges in General Dentistry: Evaluate, examine, diagnose, consult, and provide pre-, intra-, and post-operative care and perform dental procedures to patients of all ages. Services provided are within the competency scope of the provider.	X		
✔	Patient Care Assessment, Diagnosis, and Treatment Planning 1. Manage the oral health care of the infant, child, adolescent, and adult, as well as the unique needs of women, geriatric, and special needs patients. 2. Prevent, identify, and manage trauma, oral diseases, and other disorders. 3. Obtain and interpret patient/medical data, including a thorough intra/extra oral examination, and use these findings to accurately assess and manage all patients. 4. Select, obtain, and interpret diagnostic images for the individual patient. 5. Recognize the manifestations of systemic disease and how the disease and its management may affect the delivery of dental care. 6. Formulate a comprehensive diagnosis, treatment, and/or referral plan for the management of patients.	X		

Scope of Privileges and Services Provided

General dental and minor oral surgical care of medically, physically, and behaviorally compromised patients includes:

R	PROCEDURES **Dentists 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
	Operative Dentistry Direct Fillings Materials			
✔	Proper cavity design and direct placement of composite material	X		
✔	Proper cavity design and direct placement of approved restorative materials	X		
	Removable Prosthodontics: Complete and Partial Dentures			
✔	Assessment and fabrication and delivery of a cast partial denture	X		
✔	Assessment and fabrication of an acrylic partial denture	X		
✔	Assessment and fabrication of a complete denture	X		
✔	Post-operative care and adjustment of a prosthetic device	X		

✔	Assessment and repair of complete and partial dentures	X		
✔	Reline of complete and partial dentures	X		
✔	Rebase of complete and partial dentures	X		
	Oral Surgery			
✔	Removal of an erupted tooth	X		
✔	Surgical removal of an erupted tooth	X		
✔	Root recovery, depending on complexity and location of root segment	X		
✔	Alveoplasty, concurrent or non-concurrent, with extraction	X		
✔	Surgical removal of a non-complicated tooth	X		
✔	Assessment of the denture ridge in preparation of a periprosthetic procedure	X		
	Suturing of a mucosal laceration			
✔	Soft tissue intraoral biopsy	X		
✔	Treatment of post-operative bleeding	X		
✔	Treatment of minor complication from a dental extraction	X		
✔	Treatment of a dry socket	X		
✔	Intraoral IND and drain placement	X		
	Tuberosity reduction, soft tissue reduction			
	Apical cyst removal less than .5 cm			
	Fabrication of Oral Appliances for Management of Temporomandibular Joint Disorder or Myofascial Pain			
✔	Fabrication of hard and soft splints and post-delivery care	X		
	Oral Pathology and Oral Medicine			
✔	Assessment of basic oral pathological lesions	X		
✔	Treatment of oral lesions, if indicated by proper pharmacological means	X		

✔	Assessment and treatment of the oral health needs of medically complex patients – including the diagnosis and management of medical conditions that affect the oral and maxillofacial region.	X		
✔	General interpretation of a CBC	X		
✔	General interpretation of HbA1C	X		
✔	General interpretation of BS	X		
	Emergency Treatment of Infected Teeth			
✔	Assessment of a dental-alveolar infection and intraoral incision and drainage	X		
	Assessment of a dental-alveolar infection with an extraoral component			
✔	Assessment and prescribing of the appropriate antibiotic regiment	X		
	Emergency Treatment of Traumatized Teeth			
✔	Evaluation of alveolar segment fractures	X		
	Fracture stabilization			
✔	Treatment of the avulsed tooth	X		
	Nonsurgical General Periodontics and Preventive Services			
✔	Non-Surgical periodontal treatment SRP	X		
✔	Performing risk carries assessments	X		
✔	Application of flouride	X		
✔	Performing a prophy	X		
✔	Rx for flouride, if indicated	X		
	Fixed and Removable Prosthodontics Cemented or Bonded Crowns			
✔	Repair or cementation of a fixed partial denture	X		
	Endodontic Therapy			
✔	Direct pulp capping	X		
✔	Indirect pulp capping	X		
✔	Endodontic Dx and treatment planning	X		

✔	Pulpotomy	X		
	Pediatric Dental Care			
✔	Diagnostics	X		
✔	Preventative care	X		
✔	Restorative care	X		
✔	Oral surgery	X		
✔	Behavioral management techniques	X		
✔	Risk assessments CRA	X		
	Growth and development assessments			
✔	Endodontics assessments, pulpotomy, if indicated	X		
	Space maintenance procedures, unilateral and bilateral space maintainers			
✔	Orthodontic assessments, indications for orthodontic referrals	X		
✔	Pain assessment and proper pain management techniques	X		
	Other Procedures			
✔	Local anesthesia, pain and anxiety control utilizing behavioral and pharmacological techniques	X		
✔	Intraoral and extraoral radiology and imaging, includes exposing and interpreting	X		
✔	Foreign body removal from gingival tissue	X		
✔	Interpretation of basic pathology and anatomy for a Panorex radiograph	X		
✔	Intraoral and extraoral photography as part of the diagnostic procedure	X		

R	**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:	A	C	N

☐ **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. _____

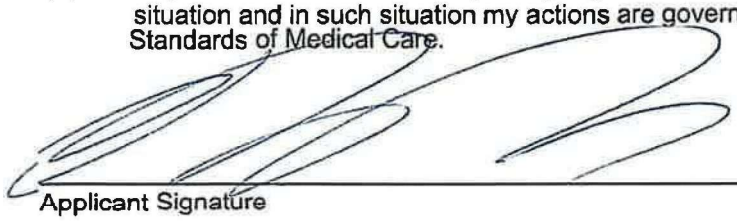
ACKNOWLEDGEMENT OF PRACTITIONER

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.



2/04/2026

Applicant Signature Date

SIGNATURE PAGE

Applicant Name: Irina Bolotnikova Privileges Effective: 4/22/2026 to 4/21/2028

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: Omar Cockey DMD MPH
0B9E8B6AF8824F2...

Signature of Director of Provider Operations	Date	Printed Name
	2/9/2026	Dr Omar T COckey MPH

Signed by: Nuha Shair
0822385E7164447...

Signature of Medical Director	Date	Printed Name
	4/1/2026 | 12:47 PM 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)

☒ **Reappointment 2026**

Provider Name: Nikhil Pillai MD **Specialty: Psychiatry and Child and Adolescent 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 4/1/2026

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: Nikhil	Middle Initial: A	Last Name: Pillai
Degree/Title: Doctor of Medicine/M.D		
Language(s) spoken: English		
Specialty: Psychiatry	Board Certified? Y ☒ N ☐	If **Y**, certifying board? American Board of Psychiatry & Neurology (ABPN)
If **N**, board eligible? Y ☐ N ☐		If **Y**, exam date:
Subspecialty: Child and Adolescent Psychiatry	Board Certified? Y ☒ N ☐	Certifying Board: American Board of Psychiatry & Neurology (ABPN)
LCHD Clinic Site(s): (this field to be completed by LCHD credentialing staff) HD-BH-CABS		

SECTION B: EDUCATION & TRAINING		
Medical School Name/City/State: American University of the Caribbean School of Medicine / Cupecoy / St Maarten		
Degree: Doctor of Medicine / M.D.	Year Graduated: 2017	
International Medical Graduate? Yes: X If Yes, ECFMG certification date: 10/17 USMLE date: _____		
Internship Name /City/State:	From:	To:
Residency 1 Name/City/State: Richmond University Medical Center / Staten Island / NY	From: 2018	To: 2021
Fellowship Name/City/State: University of New Mexico / Albuquerque / NM Child and Adolescent	From: 07/2021	To: 06/2023

SECTION C: WORK HISTORY		
Last place of employment (name/city/state): Lake County Health Department / Waukegan / IL		
Title or professional occupation: Child & Adolescent Behavioral Services	From: 04/2024	To: Present
Previous place of employment (name/city/state): John Stroger Hospital / Chicago / IL		
Title or professional occupation: Consultant Psychiatrist	From: 01/2024	To: Present
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): Pillai, Nikhil Ajit

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.

Signed by:
Nikhil Pillai
9236D716D6974D9...

2/12/2026 | 10:35 AM CST

Applicant Signature Date:

SIGNATURE PAGE

Applicant Name: Nikhil Pillai Privileges Effective: 4/22/2026 to 04/21/2028

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: Anatoliy Pyslar 59D54385BB254BD... 2/15/2026 | 8:16 PM AnatoliyPyslar MD

Signature of Medical Director of Provider Operations | Date | Printed Name

Signed by: Nuha Shair 0223385F7164447... 4/1/2026 | 12:43 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: Franceliz Recinto 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 2/13/2026

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: Franceliz	Middle Initial:	Last Name: Recinto
Degree(s), License, and APRN Certification: Masters of Science in Nursing, FPA APRN, Family Nurse Practitioner (FNP- BC)		
Language(s) spoken: English		
Name of certification examination: Family Nurse Practitioner		Certifying Body/Organization: American Nurses Credentialing Center (ANCC)
APRN Certification Start Date: 08/06/2022		APRN Certification Expiration Date: 08/05/2027
IL APRN License Number: 277.002149 Expiration Date: 05/31/2026		Full Practice Authority: Y ☒ N ☐ If N: Name of LCHD Collaborating Physician: n/a
IL RN License Number: 041354360 Expiration Date: 05/31/2026		
LCHD Clinic Site(s): (this field to be completed by LCHD credentialing staff) HD-PH-SCHOOL BASED HEALTH CENTER-ROUNDLAKE		

SECTION B: EDUCATION & TRAINING	
APRN Accredited Academic Institution Attended: School Name/City/State: University of Illinois at Chicago / Chicago / IL	
Degree: Masters of Science in Nursing	Year Graduated: 2012
New APRN graduate: List the dominant areas of clinical focus during your APRN training: Family Practice	
Experienced APRN: List the dominant areas of APRN Practice and Expertise: Pediatrics and vaccines	
Academic degree(s): Check or list any other academic degrees that you have earned: BSN: X MSN: X DNP: _____ PhD: ____ Other: _____	
Degree/Name of School/City/State of each of the above that are checked: MSN: University of Illinois at Chicago / Chicago / IL	
BSN: University of Illinois at Chicago / Chicago / IL	
Year of initial RN licensure: 2006	Years practicing as RN (before APRN): 6
RN Experience: List your dominant areas of RN practice and expertise: Pediatric intensive care	

SECTION C: WORK HISTORY		
Last place of employment (name/city/state): Lake County Health Department / Roundlake /IL		
Title or professional occupation and clinical practice area(s): APRN	From: 2020	To: Present
Previous place of employment (name/city/state): CVS Minute Clinic Mundelein / IL		
Title or professional occupation and clinical practice area(s): APRN	From: 2012	To: 2020
Previous place of employment (name/city/state): Lurie Children's Hospital, Chicago, IL		
Title or professional occupation and clinical practice area(s): RN, PICU	From: 2008	To: 2014
Last place of employment (name/city/state): Children's Hospital of Wisconsin, Milwaukee, WI		
Title or professional occupation and clinical practice area(s): RN, PICU	From: 2006	To: 2008
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): Recinto / Franceliz / Ramos

Name of Certifying Body: American Nurses Credentialing Center ANCC

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.

02/05/2026

Applicant Signature | Date

SIGNATURE PAGE

Applicant Name: Franceliz Recinto Privileges Effective: 4/22/2026 to 4/21/2028

Rationale for revision (if applicable):

continue patient care

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 A10EAFDFDD2C4F8...

Signature of Director of Provider Operations	Date: 2/10/2026 | 4:52 PM CST	Printed Name: Toni Steres

Signed by: Nuha Shair 0622385E7164471...

Signature of Medical Director	Date: 3/9/2026 | 4:49 PM CDT	Printed Name: 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)

☒ **Reappointment 2026**

Provider Name: Christine Reynolds APRN **Specialty: Psychiatric Mental Health 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 N/A Telehealth Provider

☒ 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 04/16/2026

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: **Christine**	Middle Initial: **M**	Last Name: **Reynolds**
Degree(s), License, and APRN Certification: **Doctor of Nursing Practice (DNP), Full Practice Authority APRN, Psychiatric Mental Health Nurse Practitioner**		
Language(s) spoken: **English**		
Name of certification examination: **Psychiatric – Mental Health**		Certifying Body/Organization: **American Nurse Credentialing Center**
APRN Certification Start Date: **07/31/2023**		APRN Certification Expiration Date: **07/30/2028**
IL APRN License Number: **277001738** Expiration Date: **05/31/2028**		Full Practice Authority: Y ☒ N ☐ If N: Name of LCHD Collaborating Physician:
IL RN License Number: **041338351** Expiration Date: **05/31/2028**		
LCHD Clinic Site(s): (this field to be completed by LCHD credentialing staff) **Tele- Psych- Remotely**		
SECTION B: EDUCATION & TRAINING		
APRN Accredited Academic Institution Attended: **School Name/City/State: University of Missouri / Columbia / Missouri**		
Degree: Psychiatric Mental Health Nurse - **DNP**		Year Graduated: **2018**
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: **Psychiatric - Mental Health**		
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: University of Missouri / Columbia / MO**		
MSN: University of Missouri / St Louis / MO		
BSN: Southern Illinois University Edwardsville / Edwardsville / IL		
Year of initial RN licensure: **2003**	Years practicing as RN (before APRN): **15**	
RN Experience: List your dominant areas of RN practice and expertise: **Behavioral Health**		

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): **Psychiatric Mental Health Nurse Practitioner**	From: **07/2024**	To: **Present**
Previous place of employment (name/city/state): **Sertoma Star / Matteson / IL**		
Title or professional occupation and clinical practice area(s): **Psychiatric Mental Health Nurse Practitioner**	From: **12/2023**	To: **Present**
Previous place of employment (name/city/state): **Grundy County Health Department / Morris / IL**		
Title or professional occupation and clinical practice area(s): **Psychiatric Mental Health Nurse Practitioner**	From: **09/2021**	To: **Present**
Previous place of employment (name/city/state): **Intermountain Health Center / Tucson / AZ**		
Title or professional occupation and clinical practice area(s): **Psychiatric Mental Health Nurse Practitioner**	From: **08/2021**	To: **02/2024**
Previous place of employment (name/city/state): **Black Family & Child Services / Phoenix / AZ**		
Title or professional occupation and clinical practice area(s): **Psychiatric Mental Health Nurse Practitioner**	From: **06/2019**	To: **07/2021**
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 PSYCHIATRIC-MENTAL HEALTH NURSE PRACTITIONER

☐ **Initial Appointment** ☑ **Reappointment** ☐ **Revision**

(you **must** select one)

Name (Last/First/Middle): Reynolds / Christine Marie

Name of Certifying Body: American Nurses Credentialing Center ANCC

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.

All Areas: All Core Privileges require the Psychiatric-Mental Health Nurse Practitioner (PMHNP) to have at least one registered collaborating physician, unless approved for Independent Practice Privileges.

General Psychiatry: Criteria for requesting general privileges in psychiatry are successful completion of a Master of Science in Nursing (MSN) or Doctor of Nursing Practice (DNP) degree from a PMHNP program accredited by the National League for Nursing Accrediting Commission (NLNAC), the Commission on Collegiate Nursing Education (CCNE), or the Accreditation Commission on Education for Nursing (ACEN).

Also required is initial and continuing certification as a PMHNP by the American Nurses Credentialing Center (ANCC) or other national certifying body as required by state law.

Child Psychiatry: Criteria for requesting general privileges in psychiatry are successful completion of a Master of Science in Nursing (MSN) or Doctor of Nursing Practice (DNP) degree from a PMHNP program accredited by the National League for Nursing Accrediting Commission (NLNAC), the Commission on Collegiate Nursing Education (CCNE), or the Accreditation Commission on Education for Nursing (ACEN).

Also required is initial and continuing certification as a PMHNP-BC by the American Nurses Credentialing Center (ANCC) or other national certifying body as required by state law.

Addiction Psychiatry: Criteria for requesting privileges in Addiction Psychiatry are the same as those for General Psychiatry with sufficient cumulative working experience in the field as determined by the Behavioral Health Medical Director.

Also required is initial and continuing certification as a PMHNP-BC by the American Nurses Credentialing Center (ANCC) or other national certifying body as required by state law, with or without current initial and continuing certification as a Certified Addictions Registered Nurse – Advanced Practice (CARN-AP) by the Addictions Nursing Certification Board (ANCB).

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
✔	Assessment, 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. Refer patients to other health care providers as indicated. Provide urgent care as indicated. 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
✔	Assessment, 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, all forms of psychological and social treatment, and individual psychotherapy with or without evaluation and management. Privileges also include providing consultation with clinicians in other fields regarding addictive disorders and MAT. Core privileges do not include privileges in ECT.			

R	FULL PRACTICE AUTHORITY	A	C	N
✔	Privileges as above without registration of a collaborating physician, except in circumstances limited by state law.	✔		

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			

Qualifications for 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:

Individual Psychotherapy: Completion of an accredited training program in Psychotherapy in which group psychotherapy was required and practiced under supervision, or sufficient cumulative working experience as determined by the Behavioral Health Medical Director.

Group Psychotherapy: Completion of an accredited training program in Group Psychotherapy in which group psychotherapy was required and practiced under supervision, or sufficient cumulative working experience as determined by the Behavioral Health Medical Director.

Family Psychotherapy: Completion of an accredited training program in Group Psychotherapy in which group psychotherapy was required and practiced under supervision, or sufficient cumulative working experience as determined by the Behavioral Health Medical Director.

R	SPECIAL PROCEDURES	A	C	N
✔	Individual Psychotherapy	✔		
	Group Psychotherapy			
	Fami ly Psychotherapy			

☐ **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.

Christine Reynolds, MSN, PMHNP-BC — 4-10-26

Applicant Signature — Date

SIGNATURE PAGE

Applicant Name: Christine Reynolds Privileges Effective: 5/27/2026 to 5/26/2028

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
0E3784D8938344D...

Signature of Medical Director of Provider Operations	Date	Printed Name
	4/15/2026 | 1:48 PM CDT	Reddy, Daram

Signed by:
Nuha Shair
062[illegible]

Signature of Medical Director	Date	Printed Name
	5/14/2026 | 9:29 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