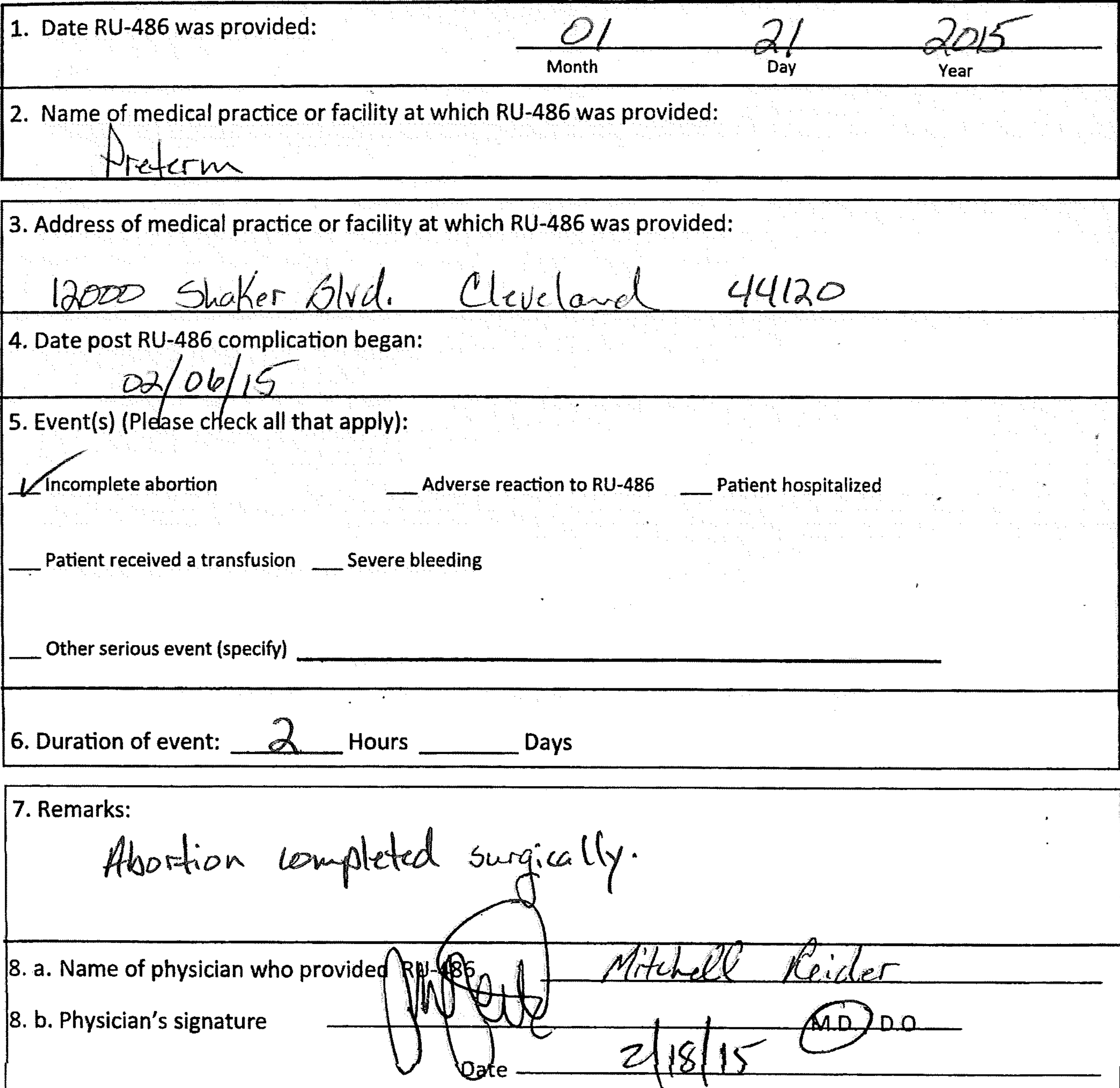
State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486



1. Date RU-486 was provided: 01 (Month) 21 (Day) 2015 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Preterm

3. Address of medical practice or facility at which RU-486 was provided:
12000 Shaker Blvd. Cleveland 44120

4. Date post RU-486 complication began:
02/06/15

5. Event(s) (Please check all that apply):

✓ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) ______

6. Duration of event: 2 Hours ______ Days

7. Remarks:
Abortion completed surgically.

8. a. Name of physician who provided RU-486 Mitchell Reider

8. b. Physician's signature ______ M.D. (circled) D.O

Date 2/18/15

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD

FEB 20 2015

Prescribed: 5/--/2011, Rev. 12/13/12

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: Month 06 Day 10 Year 15

2. Name of medical practice or facility at which RU-486 was provided:
Preterm

3. Address of medical practice or facility at which RU-486 was provided:
12000 Shaker Blvd. Cleveland 44120

4. Date post RU-486 complication began: 7/3/15

5. Event(s) (Please check all that apply):

✓ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) ______________________

6. Duration of event: 2 Hours ________ Days

7. Remarks:
Abortion completed surgically.

8. a. Name of physician who provided RU-486 Mitchell Reider

8. b. Physician's signature [signature] (M.D.) / D.O

Date 7/16/15

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD
JUL 20 2015

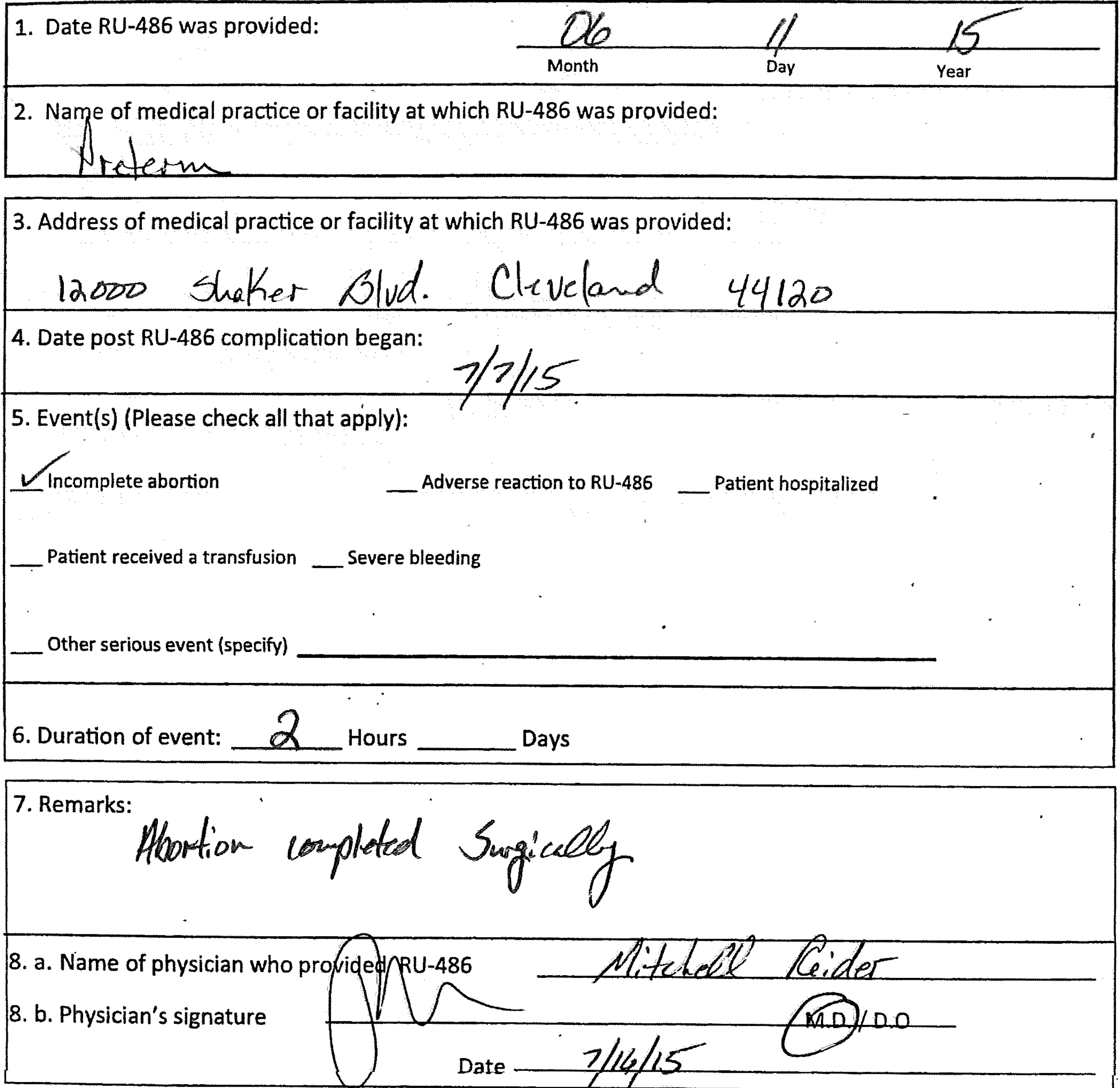
Prescribed: 5/--/2011, Rev. 12/13/12

State Medical Board of Ohio

Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486



1. Date RU-486 was provided: 06 (Month) 11 (Day) 15 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Preterm

3. Address of medical practice or facility at which RU-486 was provided:
12000 Shaker Blvd. Cleveland 44120

4. Date post RU-486 complication began:
7/7/15

5. Event(s) (Please check all that apply):

✓ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) ______________________

6. Duration of event: 2 Hours ________ Days

7. Remarks:
Abortion completed Surgically

8. a. Name of physician who provided RU-486 Mitchell Reider

8. b. Physician's signature [signature] (M.D.) / D.O

Date 7/16/15

Send completed forms to: State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

JUL 20 2015

Prescribed: 5/--/2011, Rev. 12/13/12

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	09 (Month)	10 (Day)	15 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Preterm

3. Address of medical practice or facility at which RU-486 was provided:
12000 Shaker Blvd. Cleveland 44120

4. Date post RU-486 complication began: 10/01/15

5. Event(s) (Please check all that apply):

✓ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) ____________________

6. Duration of event: 2 Hours ________ Days

7. Remarks:
Abortion completed surgically.

8. a. Name of physician who provided RU-486 Mitchell Reider, M.D.

8. b. Physician's signature [signature] (M.D.) / D.O

Date 10/10/15

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

Prescribed: 5/--/2011, Rev. 12/13/12

MEDICAL BOARD

OCT 15 2015

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 09 (Month) 24 (Day) 15 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Preterm

3. Address of medical practice or facility at which RU-486 was provided:
12000 Shaker Blvd. Cleveland 44120

4. Date post RU-486 complication began: 10/10/15

5. Event(s) (Please check all that apply):

✓ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) ______

6. Duration of event: 2 Hours ______ Days

7. Remarks:
Abortion completed surgically.

8. a. Name of physician who provided RU-486 Mitchell Rider, M.D.

8. b. Physician's signature ______ (M.D.) / D.O

Date 10/16/15

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD
OCT 19 2015

Prescribed: 5/--/2011, Rev. 12/13/12