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:	04 (Month) 12 (Day) 17 (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:	
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:	
8. a. Name of physician who provided RU-486	Mohammad Rezae, M.D.
8. b. Physician's signature	[signature] MD/DO
Date	5/6/17

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

MEDICAL BOARD
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