



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:	<u>03</u>	<u>12</u>	<u>15</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>03/28/15</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Lisa Pentiera</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>4/16/15</u>			

Send completed forms to: State Medical Board of Ohio

Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD

APR 20 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:	<u>01</u>	<u>22</u>	<u>15</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Pretarm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>2/13/15</u>			
5. Event(s) (Please check all that apply):			
<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized			
<input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding			
<input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Lisa Ferreira</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>2/26/15</u>			

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MAR 2 2015



State Medical Board of Ohio Report of RU-486 Event

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To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>10</u> Month	<u>23</u> Day	<u>14</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Proform</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleve. OH 44120</u>			
4. Date post RU-486 complication began: <u>11/8/14</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Lisa Ferreira</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/D.O.</u> Date <u>11/14/14</u>			

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OF OHIO
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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:	<u>08</u>	<u>28</u>	<u>14</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>09/12/14</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>4</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Lisa Ferreira</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u> Date <u>9/19/14</u>			

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MEDICAL BOARD

SEP 22 2014



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:	<u>07</u>	<u>03</u>	<u>14</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Academy</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd.</u>			
4. Date post RU-486 complication began: <u>8/2/14</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>1</u> Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Lisa Ventura</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. _____			
Date <u>8/8/14</u>			

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MEDICAL BOARD
AUG 11 2014

Sept 20



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>08</u>	<u>30</u>	<u>2012</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Arcterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleve. OH 44120</u>			
4. Date post RU-486 event began: <u>9/12/12</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically 9/12/12, no further complication.</u>			
8. a. Name of physician who provided RU-486 <u>Lisa Perrica, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> <u>(M.D./D.O.)</u>			
Date <u>9/14/12</u>			

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MEDICAL BOARD

SEP 24 2012

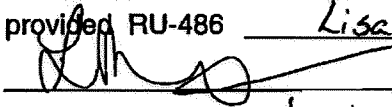
Rpt #2



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
05 Month	04 Day	2011 Year
2. Name of medical practice or facility at which RU-486 was provided: Proterm		
3. Address of medical practice or facility at which RU-486 was provided: 12000 Shaker Blvd. Cleveland 44120		
4. Date post RU-486 event began: 05/11/11		
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: 2 Hours _____ Days		
7. Remarks: Abortion completed surgically 5/11/11, no further complication.		
8. a. Name of physician who provided RU-486 Lisa Pennera, M.D.		
8. b. Physician's signature  M.D. / D.O. Date 7/12/11		

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