

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

| 1. Date RU-486 was provid | ed: | 03 | 12 | 15 |
|--------------------------------|------------------------------------|--------------------|----------------------|-------|
| | | Month | Day | Year |
| 2. Name of medical practic | e or facility at which | RU-486 was provid | ed: | |
| 3. Address of medical pract | ice or facility at which | n RU-486 was provi | ded: | |
| 12000 Shel | her Blvd. | Clevelan | d 44120 | |
| 4. Date post RU-486 compl | | 3/28/15 | | |
| 5. Event(s) (Please check al | . 1 | 1. | | • |
| Incomplete abortion | Adverse | reaction to RU-486 | Patient hospitalized | |
| Patient received a transfusion | n Severe bleeding | | | |
| Other serious event (specify | | | | |
| 6. Duration of event: | Hours | Days | | |
| 7. Remarks: | completed su | wgically. | | |
| 8. a. Name of physician who | o provided RU-486 | Lisa | Petriera | |
| 8. b. Physician's signature | Date | 4/16/15 | (no)/0 | 0 |
| Send completed forms to: | State Medic | al Board of Ohio | | |
| | Legal Department | | | · _ / |
| | 30 E. Broad St., 3 rd I | Floor | MEDICAL B | OARD |
| | Columbus, OH 432 | 15-6127 | APP 90 2 | n4E |



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

| 1. Date RU-486 was provide | ed: | 01 | 22 | 15 |
|------------------------------------------------------------|----------------------|-----------------------|----------------------|------|
| | | Month | Day | Year |
| 2. Name of medical practice Preterv | | ch RU-486 was pro | ovided: | |
| 3. Address of medical practi | ce or facility at wh | ich RU-486 was p | rovided: | |
| 12000 Shaker | Blvd. | Clevelar | d 4412 | 6, |
| 4. Date post RU-486 complic | | | | |
| 5. Event(s) (Please check all | that apply): | | | |
| Incomplete abortion | Adver | se reaction to RU-486 | Patient hospitalized | L , |
| Patient received a transfusion | Severe bleedin | g | | |
| Other serious event (specify) | | | | |
| 6. Duration of event: | Hours | Days | | |
| 7. Remarks: | complete | ed surgica | ely. | • |
| 8. a. Name of physician who 8. b. Physician's signature | (A) | LIS | a Perriesa (MD) | D.O |
| Send completed forms to: | State Med | dical Board of Ohi | 0 | |
| | Legal Departmen | | | |
| | 30 E. Broad St., 3 | rd Floor | | |
| | Columbus, OH 4 | 3215-6127 | MEDICAL BO | ARD |

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

MAR 2 2015



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

| 1. Date RU-486 was provided: | 10 | 23 | 14 |
|-----------------------------------------------------------------------|-----------------------------|----------------------|--------------|
| | Month | Day | Year |
| 2. Name of medical practice or facility a | at which RU-486 was prov | ided: | |
| 3. Address of medical practice or facility | at which RU-486 was pro | ovided: | |
| 12000 Shaker Blvd. | Cleve. OH | 44120 | |
| 4. Date post RU-486 complication began | n: | | S1 2 |
| 5. Event(s) (Please check all that apply): | _Adverse reaction to RU-486 | Patient hospitalized | ZOJIL NOV 18 |
| Patient received a transfusion Severe | bleeding | | AM IO: 08 |
| Other serious event (specify) | | | _ & & |
| 6. Duration of event: Hours | Days | | |
| 7. Remarks: Abortion completed | I surgically. | | |
| 8. a. Name of physician who provided R 8. b. Physician's signature | Date 4150 | Herriera MD/De | 0 |
| Send completed forms to: Sta | te Medical Board of Ohio | | |
| Legal Depa | | | |
| 30 E. Broad | St., 3 rd Floor | | |

Columbus, OH 43215-6127



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

| 1. Date RU-486 was provid | led: | 08 | 24 | 14 |
|-----------------------------------------|------------------------|----------------------|----------------------|------|
| | | Month | Day | Year |
| 2. Name of medical praction | ce or facility at whic | h RU-486 was provid | led: | |
| 3. Address of medical pract | ice or facility at whi | ch RU-486 was prov | ided: | |
| 12000 Shak | er Blvd. | Cleveland | 44120 | |
| 4. Date post RU-486 compl | ication began: | 09/12/14 | | |
| 5. Event(s) (Please check al | | 1 /. | | |
| Incomplete abortion | Advers | e reaction to RU-486 | Patient hospitalized | |
| Patient received a transfusion | on Severe bleeding | | | |
| | | | | |
| Other serious event (specify |) | | | |
| 6. Duration of event: | Hours | Days | | |
| 7. Remarks: | - completed | d surgically | <i>y</i> . | |
| 8. a. Name of physician wh | o provided RY-486 | Lisa | Derriera | |
| 8. b. Physician's signature | | ate 9 19 | MD/D | 0 |
| Send completed forms to: | | ical Board of Ohio | | |
| han a war alandi afili, kalanda kiji ji | Legal Department | | | · |
| | 30 E. Broad St., 3 | ^d Floor | | 77 |
| | Columbus, OH 43 | 215-6127 | MEDICAL BOA | (KD |
| | | | SEP 2 2 2014 | |



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

| 1. Date RU-486 was provided: | _07 | 03 | 14 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|---------------------|-------------|
| | Month | Day | Year |
| 2. Name of medical practice or facility at w | vhich RU-486 was provide | ed: | |
| 3. Address of medical practice or facility at | which RU-486 was provi | ded: | |
| 12000 Shaker Blvd. | | | |
| 4. Date post RU-486 complication began: | | | |
| 5. Event(s) (Please check all that apply): | | | |
| Incomplete abortion Ad | lverse reaction to RU-486 _ | Patient hospitalize | d . |
| | | | |
| Patient received a transfusion Severe blee | eding | | , |
| Patient received a transfusion Severe blee | eding | | |
| Other serious event (specify) | | | |
| | | | |
| Other serious event (specify) 6. Duration of event: Hours | Days | | r 1 |
| Other serious event (specify) 6. Duration of event: Hours 7. Remarks: | Days rgically. | Aen: cma/ | · · · |
| Other serious event (specify) 6. Duration of event: Hours 7. Remarks: Aborton completed Su | Days rgically. 186 Lisa | Aeniera/ Wol | |
| Other serious event (specify) 6. Duration of event: Hours 7. Remarks: Abortion (outlided Summer of physician who provided RU) 8. a. Name of physician who provided RU) 8. b. Physician's signature | Days rgically. | Th | D.O. |

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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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

| Date RU-486 was provided: | 08 | 30 | 2012 |
|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------|----------------|
| | Month | Day | Year |
| Name of medical practice or facil Areterm | ity at which RU-486 was | provided: | |
| 3. Address of medical practice or factor 12000 Shaker Blvd | | | |
| 4. Date post RU-486 event began: | 9/12/12 | | |
| 5. Event(s) (Please check all that ap | ply): | | |
| | _ Adverse reaction to RU-486 | Patient | t hospitalized |
| Patient received a transfusion | _ Severe bleeding | | |
| Other serious event (specify) | | | |
| 6. Duration of event: Ho | urs Days | | |
| 7. Remarks: Alsortion completed surgice | cely 9/12/12, no f | wither comple | ication. |
| 8. a. Name of physician who provide | RU-486 Lisa X | Petriera, M. | · |
| 8. b. Physician's signature | | | M.D. /\D.O |
| er er i riyeletari e eigilatare ===== | Date 9/14/ | 1/2 | W.D. 70.0 |
| Leg 30 | ite Medical Board of Ohio gal Department E. Broad St., 3 rd Floor lumbus, OH 43215-6127 | WE | SEP 2 4 2012 |

Rept#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

| Date RU-486 was provided: | _ 05 | 04 | 2011 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| | Month | Day | Year |
| 2. Name of medical practice or facility Archerm | y at which RU-486 was p | rovided: | |
| 3. Address of medical practice or facil | lity at which RU-486 was | provided: | |
| | | William Control of the Control of th | • |
| 12,000 Shaker Blvd. 4. Date post RU-486 event began: | 05/11/11 | | |
| 5. Event(s) (Please check all that app | ly): | | |
| Incomplete abortion | Adverse reaction to RU-486 | Patient hos | pitalized |
| Patient received a transfusion | Severe bleeding | | |
| Other serious event (specify) | | | |
| 6. Duration of event: 2 Hou | rs Days | | |
| 7. Remarks: | | <u> </u> | · . · · · · · · · · · · · · · · · · · · |
| Abortion completed su | ngically 5/11/11, no | Switter con | plication. |
| 8. a. Name of physician who provided | RU-486 <u>Lisa</u> | Perriera, N | ١,٥، |
| 8. b. Physician's signature | MA | , | M.D.) D.O |
| or by the state of | Date 7/12/11 | | |
| Send completed forms to: Stat | e Medical Board of Ohio | | |
| . Leg | al Department | | |
| 30 E | E. Broad St., 3 rd Floor | | |
| Cole | umbus, OH 43215-6127 | MEDIC | AL BOARD |

Prescribed: 5/--/2011

JUL 19 2011