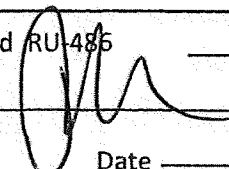


State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
07 Month	30 Day	16 Year
2. Name of medical practice or facility at which RU-486 was provided: Aetna		
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: 08/13/16		
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: 1 Hours _____ Days		
7. Remarks:		
8. a. Name of physician who provided RU-486: Mitchell Reider, M.D.		
8. b. Physician's signature:  M.D./D.O.		
Date: 8/20/16		

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

MEDICAL BOARD



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>06</u> Month	<u>17</u> Day	<u>16</u> 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>07/05/16</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>Mitchell Reider, M.D.</u>			
8. b. Physician's signature _____ Date <u>7/8/16</u> <u>M.D. D.O.</u>			

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MEDICAL BOARD

JUL 12 2016



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>04</u> Month	<u>29</u> Day	<u>16</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Praterm</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>5/13/16</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 _____ Days <u>unknown</u>			
7. Remarks: <u>Abortion completed surgically elsewhere.</u>			
8. a. Name of physician who provided RU-486 <u>Mitchell Reider, M.D.</u>			
8. b. Physician's signature _____ Date <u>6/1/16</u> <u>MD/DO</u>			

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MEDICAL BOARD



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: 03 30 2016
Month Day Year

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

Arterm

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:

04/26/16

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: 3 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]

MD/DO

Date

4/27/16

Send completed forms to:

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MEDICAL BOARD

MAY 2 2016

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>09</u> Month	<u>24</u> Day	<u>15</u> 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>10/10/15</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>Mitchell Reider, M.D.</u>			
8. b. Physician's signature: _____ Date: <u>10/16/15</u> <u>M.D.</u> <u>D.O.</u>			

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MEDICAL BOARD

OCT 19 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>09</u>	<u>10</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>10/01/15</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>Mitchell Reider, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> <u>M.D. / D.O.</u>			
Date <u>10/10/15</u>			

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Columbus, OH 43215-6127



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>06</u>	<u>10</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>7/3/15</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>Mitchell Rider</u>			
8. b. Physician's signature <u>[Signature]</u> <u>M.D./D.O.</u>			
Date <u>7/16/15</u>			

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JUL 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

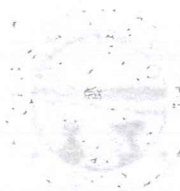
1. Date RU-486 was provided:	<u>06</u>	<u>11</u>	<u>15</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Proform</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>7/7/15</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>Mitchell Reider</u>			
8. b. Physician's signature <u>[Signature]</u> <u>M.D./D.O.</u>			
Date <u>7/16/15</u>			

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JUL 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>21</u>	<u>2015</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>02/06/15</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>Mitchell Reider</u>			
8. b. Physician's signature <u>[Signature]</u> <u>2/18/15</u> <u>M.D./D.O.</u>			

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FEB 20 2015