

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	07	<i>30</i>	16
	Month	Day	Year
2. Name of medical practice or facility at w	hich RU-486 was prov	ided:	
3. Address of medical practice or facility at 12000 Shaker Blvd.			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Ad	verse reaction to RU-486	Patient hospitalize	e <b>d</b>
Patient received a transfusion Severe blee	ding		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:			
8. a. Name of physician who provided RU4 8. b. Physician's signature	Date 8 20	hell Reider	, M.D.
Send completed forms to: State N	Medical Board of Ohio		
Legal Departm			

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127

MEDICAL BOARD

SEP 6 2016



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	_06	17	16
	Month	Day	Year
2. Name of medical practice or facility at	which RU-486 was provi	ded:	
3. Address of medical practice or facility a			
4. Date post RU-486 complication began:	07/05/16		
5. Event(s) (Please check all that apply):			
	Adverse reaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion Severe ble	eeding		
Other serious event (specify)			
6. Duration of event: $2$ Hours _	Days		
7. Remarks: Abortion completed surgi	ally.		
8. a. Name of physician who provided RU	-486 \ \ \ MILES	A Rider	M.D.
8. b. Physician's signature	Date 78	14	)n.o
Send completed forms to: State	Medical Board of Ohio		
Legal Depart	ment		
30 E. Broad S	St., 3 <sup>rd</sup> Floor		
Columbus, O	H 43215-6127	MEDICAL I	BOARD

JUL 12 2016

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



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provide	ded:	04	29	1/2	•
		Month	Day	Year	
2. Name of medical practi	ce or facility at whic	ch RU-486 was pro	vided:		
3. Address of medical prac	tice or facility at wh				
4. Date post RU-486 complete S/13/16	lication began:	CHNAXI			
5. Event(s) (Please check a					
Incomplete abortion	Adver	se reaction to RU-486	Patient hosp	italized	
Patient received a transfusion	on Severe bleedin	ğ			
Other serious event (specify					
6. Duration of event:	Hours	Days Un	Known		
7. Remarks:					
Abortion comp	leted surgiced	Oly March	ure,		
8. a. Name of physician wh	o provided RU-486	o Mitela	Q Reido	M.D.	
8. b. Physician's signature	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	te Cel	116	1000	
Send completed forms to:	State Med	) dical Board of Ohio	)		
	Legal Departmen	t		* * * * * * * * * * * * * * * * * * * *	
	30 E. Broad St., 3	<sup>rd</sup> Floor		•	
	Columbus, OH 4:	3215-6127	MEDICA	L BOARD	
Prescribed: 5//20≨1, Rev. 12/13/12	·		JUN	6 2016	



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provid	ded:	23	30	2016
		Month	Day	Year
2. Name of medical practic	ce or facility at which	RU-486 was provi	ded:	
3. Address of medical pract	tice or facility at which	ch RU-486 was prov	vided:	
12000 Shaker	Blud. CI	eveland	44120	
4. Date post RU-486 compl	ication began:			
5. Event(s) (Please dheck al	I that apply):			
Incomplete abortion	Adverse	reaction to RU-486	Patient hospitalized	
Patient received a transfusion	on Severe bleeding			
Other serious event (specify	)			
6. Duration of event:	3 Hours	Days		
7. Remarks:	completed	Surgically.		
8. a. Name of physician who	o provided RU-486	4/	Reider, M	.0.
Send completed forms to:	State Medi	cal Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 <sup>rd</sup>		MEDICAL	BOARD
	Columbus, OH 432	215-6127	MAV 9	2016



(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	15
2. Name of medical practice of the section	or facility at which RU		ed:	Year
3. Address of medical practice				
4. Date post RU-486 complicat	tion began: 10/10/1	5		
5. Event(s) (Please check all th	11			
Incomplete abortion	Adverse rea	ction to RU-486 _	Patient hospitalize	d .
Patient received a transfusion	Severe bleeding			
Other serious event (specify)				nen-kangungan
6. Duration of event: 2	Hours	Days		
7. Remarks:	steted surgica	æj.		
8. a. Name of physician who p 8. b. Physician's signature	rovided RU-486	Mitchel 10/16/13	Me Cerder	M.D.
Send completed forms to:	State Medical I	Board of Ohio		
L	egal Department			
	0 E. Broad St., 3 <sup>rd</sup> Flo		LATT	DICH DO DD
C	columbus, OH 43215-	6127	MEI	DICAL BOARD

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

OCT 19 2015



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	09	10	15
	Month	Day	Year
2. Name of medical practice or facility at	which RU-486 was provid	ded:	
3. Address of medical practice or facility a	at which RU-486 was prov	vided:	,
12,000 Shaker Blvd.			
4. Date post RU-486 complication began:	10/01/15		
5. Event(s) (Please check all that apply):	1.		
Incomplete abortion	Adverse reaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion Severe bl	eeding		
Other serious event (specify)			
6. Duration of event: 2 Hours	Days		
7. Remarks: Abortion completel	I sugically.		
8. a. Name of physician who provided RU 8. b. Physician's signature	Date 10/10/1	hell Reide	1, M.D.
Send completed forms to: State	Medical Board of Ohio		
Legal Depart	tment	·	
30 E. Broad	St., 3 <sup>rd</sup> Floor		
Columbus, C	DH 43215-6127		

MEDICAL BOARD

OCT 1 5 2015



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provid	led:	06	10	15
		Month	Day	Year
2. Name of medical practic	ce or facility at w	hich RU-486 was pro	vided:	
3. Address of medical pract	ice or facility at	which RU-486 was pr	ovided:	
12000 Shaker				
4. Date post RU-486 compl	ication began:	3/15		
5. Event(s) (Please check al	I that apply):			
Incomplete abortion	Ad	verse reaction to RU-486	Patient hospitalize	d
Patient received a transfusion	on Severe blee	ding		
Other serious event (specify				
6. Duration of event:	Z Hours	Days		
7. Remarks:				
Abortion co	myptofed	surgically.		
8. a. Name of physician wh	o provided RV4	86 M	Fell Rig	ler
8. b. Physician's signature		Date 7	116/15	D.O
Send completed forms to:	State N	/ /ledical Board of Ohio	) .	
	Legal Departm	ent		
	30 E. Broad St.	., 3 <sup>rd</sup> Floor	MEDICAL BO	DARD
	Columbus, OH	43215-6127		
			JUL 20 20	115



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		06	//	15
		Month	Day	Year
2. Name of medical practice or	facility at whi	ch RU-486 was provid	ded:	
3. Address of medical practice of	or facility at wh	nich RU-486 was prov	rided:	
12000 Shaker	Blud.	Cheveland	44120	
12000 Shaker 4. Date post RU-486 complicati	on began:	1/2/15		
5. Event(s) (Please check all tha	t apply):	1		
Incomplete abortion	Adve	rse reaction to RU-486	Patient hospitaliz	ed .
Patient received a transfusion	Severe bleedir	ng		
Other serious event (specify)		,		
6. Duration of event:	Hours	Days		
7. Remarks: Abortion con	-ploted	Swg! celly.		
8. a. Name of physician who pro 8. b. Physician's signature	W.	Mite Date 7/16/15	Lell Reid	/D.O
Send completed forms to:	State Me	dical Board of Ohio		
	gal Departmer			<i>f</i>
	E. Broad St., 3			
Co	lumbus, OH 4	3215-6127	M	EDICAL BOARD

JUL 2 0 2015

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	01	21	2015
	Month	Day	Year
2. Name of medical practice or facility at w	hich RU-486 was prov	ided:	
3. Address of medical practice or facility at	which RU-486 was pro	ovided:	
12000 Shaker Blvd.	Cleveland	44120	
4. Date post RU-486 complication began:			
02/06/15			
5. Event(s) (Please check all that apply):			
Ad	verse reaction to RU-486	Patient hospitalize	d .
Patient received a transfusion Severe blee	ding		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks: Abortion completed	surgically.		
8. a. Name of physician who provided RN-98. b. Physician's signature	the	hell Reide	
Send completed forms to: State N	Medical Board of Ohio nent		•

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127

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FEB 2 0 2015