

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided		07	06	16
		Month	Day	Year
2. Name of medical practice of the lense of	or facility at which RL	I-486 was prov	rided:	
3. Address of medical practice	e or facility at which R	U-486 was pro	ovided:	
12000 Sheker L			44120	
4. Date post RU-486 complica	tion began:			
5. Event(s) (Please check all th	nat apply):			
<b>✓</b> Incomplete abortion	Adverse rea	ction to RU-486	Patient hospitalize	d
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 p	provided RU-486	Moha	mmad Possee	и.б.
8. b. Physician's signature	MAG.	201 y 3	.r/6 MD	/DO
Send completed forms to:	State Medical	Board of Ohio		
	egal Department			
The state of the s	30 E. Broad St., 3 <sup>rd</sup> Flo	or		
(	Columbus, OH 43215	-6127		

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

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:	02	23	20%
	Month	Day	Year
2. Name of medical practice or facility at wh	ich RU-486 was provi	ded:	
3. Address of medical practice or facility at w	hich RU-486 was prov	vided:	
12000 Shaker Blud.	Cleveland	4412	D
4. Date post RU-486 complication began:	16/16		
5. Event(s) (Please check all that apply):	1		
Adve	erse reaction to RU-486	Patient hospitalize	ed .
Patient received a transfusion Severe bleedi	ing		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks: Abortion completed	surgically.		
8. a. Name of physician who provided RU-48	6 Mohan	mad Rozace	2
8. b. Physician's signature	Date —	4616 MD	20
Send completed forms to:  State Mo Legal Departme 30 E. Broad St.,			

Columbus, OH 43215-6127

MEDICAL BOARD
APR 11 2016



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provid	led:	02	24	16
		Month	Day	Year
2. Name of medical practice.  Areferm	ce or facility at wh	nich RU-486 was provid	ed:	
3. Address of medical pract				
12,000 Shakes	- Blud.	Cleveland	44120	
4. Date post`RU-486 compl	ication began:			
5. Event(s) (Please check al	l that apply):			
Incomplete abortion	Adv	erse reaction to RU-486	Patient hospitalized	· .
Patient received a transfusion	on Severe bleed	ling		
Other serious event (specify	)	•		
6. Duration of event:	Hours	Days		
7. Remarks:	completed	surgially.		
8. a. Name of physician who	o provided RU-48	36 Moham	mad Perse	ee
8. b. Physician's signature	-000	Date 461	(C MD)	bo
Send completed forms to:	State M	edical Board of Ohio		
	Legal Departme	ent		
	30 E. Broad St.,	3 <sup>rd</sup> Floor	MEDICAL	BOARD
	Columbus, OH	43215-6127	APR 11	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	16	15
		Month	Day	Year
2. Name of medical practice of the second se	or facility at wh	ich RU-486 was provide	ed:	
3. Address of medical practice	or facility at w	hich RU-486 was provi	ded:	
12000 Sheker	Blvd.	Cleveland	44120	
4. Date post RU-486 complica	tion began:	15		
5. Event(s) (Please check all th		•		
/Incomplete abortion	Adve	rse reaction to RU-486	Patient hospitalize	d .
Patient received a transfusion	Severe bleedi	ng		
Other serious event (specify)	•			
6. Duration of event: 2.5	Hours	Days		
7. Remarks:				
Abortion co	nupleled	sugically.		
8. a. Name of physician who p	rovided RU-48	Mohan	mad Roze	Ree
8. b. Physician's signature	MM	Date - 1/14	/15 MD)	D.O
Send completed forms to:	State Me	edical Board of Ohio		
1	egal Departme.	nt		
3	30 E. Broad St.,	3 <sup>rd</sup> Floor		
	Columbus, OH 4	13215-6127	MEDICA	LBOARD

JUL 20 2015

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 provided:	05	06	2015
	Month	Day	Year
2. Name of medical practice or facility at Areferm	which RU-486 was provi	ded:	
3. Address of medical practice or facility a 12000 Shaker Blvd.			
4. Date post RU-486 complication began:		·	
5. Event(s) (Please check all that apply):	•		
Incomplete abortion	Adverse reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe bloom	eeding		
Other serious event (specify)			
6. Duration of event: Hours _	Days		
7. Remarks: Abortion complete	ed surgically.		
8. a. Name of physician who provided RU	-486 Moha	mucal Para	ce M.D.
8. b. Physician's signature	Date 19 6	12/15 (10)	,
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	MEDI	CAL BOARD

JUN 5

2015



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	03	ID	15
	Month	Day	Year
2. Name of medical practice or facility at	which RU-486 was pro	vided:	
3. Address of medical practice or facility a	t which RU-486 was pr	ovided:	
12000 Shaker Blvo	1. Clevela	end 4	4120
4. Date post RU-486 complication began:	04/03/15		
5. Event(s) (Please check all that apply):	1 1		
Incomplete abortion A	dverse reaction to RU-486	Patient hospitaliz	red
Patient received a transfusion Severe ble	eeding		
Other serious event (specify)			
6. Duration of event: Hours _	Days		
7. Remarks:	d surgically.		•
8. a. Name of physician who provided RU	-486 <u>Moh</u>	ammed Re-	zall
8. b. Physician's signature			) D.O
Send completed forms to: State	Medical Board of Ohio		
Legal Depart			
30 E. Broad S		MEDICAL	BOARD
Columbus, O	H 43215-6127	APR 20	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	08	14
	Month	Day	Year
2. Name of medical practice or facility at	which RU-486 was provid	led:	
3. Address of medical practice or facility a	at which RU-486 was prov	ided:	
12000 Shaker B	Ivd. Clevela	nd 44	120
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			,
Incomplete abortion	Adverse reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe bl	eeding		
Other serious event (specify)	•		
6. Duration of event: Hours _	Days		
7. Remarks: Albortion completed	surgically.		•
8. a. Name of physician who provided RU 8. b. Physician's signature	1-486 Moha, Date 10/14	uned Rosa (14	<i>el</i>
Send completed forms to: State	Medical Board of Ohio		
Legal Depar	tment		
30 E. Broad	St., 3 <sup>rd</sup> Floor		
Columbus, C	OH 43215-6127		

MEDICAL BOARD

NOV 2 0 2014



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provid	ed:	Dh	MZ	14
	<del>-</del>	Month	Day	Year
2. Name of medical practic	e or facility at which RU	-486 was prov	ided:	
3. Address of medical pract	ice or facility at which RI	J-486 was pro	vided:	
12000 Sucker	Blud. Cleve	land	44120	
4. Date post RU-486 compli	cation began: 06/20/14			
5. Event(s) (Please check all	/ / /			,
Incomplete abortion	Adverse read	tion to RU-486	Patient hospitalized	
Patient received a transfusio	n Severe bleeding			
Other serious event (specify)				
6. Duration of event:	Hours	Days		
7. Remarks: Abortion comple	ted surgically.			•
8. a. Name of physician who	provided RU-486	Mohan	uncel Rezare,	M.D.
8. b. Physician's signature	Morn	2	MD/I	
	Date –	7	19/14	
Send completed forms to:	State Medical E	Board of Ohio		
	<b>Legal Department</b>			
	30 E. Broad St., 3 <sup>rd</sup> Floo		MEDICAL I	BOARD
	Columbus, OH 43215-	6127	JUL 14	2014



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provide	d:	07	09	13
a security		Month	Day	Year
2. Name of medical practice	or facility at w	hich RU-486 was provi	ded:	·
3. Address of medical practic	e or facility at v	which RU-486 was prov	vided:	
12000 Shake	r Blvd.	Cleveland	OH 441	120
4. Date post RU-486 complic	ation began:	7/26/13		
5. Event(s) (Please check all t	hat apply):			
/Incomplete abortion	Adv	verse reaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion	Severe bleed	ling		
Other serious event (specify)				
6. Duration of event:	Hours	/ Days		
7. Remarks: Abortion comple	ted swg:	cally on 1/24	/13, no furt	her complication.
8. a. Name of physician who	provided RU-4	86 Moh	ammad Res	Lape
8. b. Physician's signature	-87	Date	1/13	
Send completed forms to:	State N	ledical Board of Ohio		
	Legal Departm	ent		
	30 E. Broad St.	, 3 <sup>rd</sup> Floor	MET	DICAL BOARD
	Columbus, OH	43215-6127	,	AUG 1 2 2013



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provid	led:	07	30	2013
		Month	Day	Year
2. Name of medical practic	ce or facility at which RU-	486 was provi	ded:	
3. Address of medical pract	ice or facility at which RU	J-486 was pro	vided:	
12000 Shake	r Blud. Cle	veland	, Dhio	44120
4. Date post RU-486 compl				
5. Event(s) (Please check al	that apply):			
Incomplete abortion	Adverse reac	tion to RU-486	Patient hospitaliz	ed
Patient received a transfusion	on Severe bleeding			
Other serious event (specify	)			
6. Duration of event:	Hours/ [	)ays		
7. Remarks: Abortion comp	total surgically	1.		
8. a. Name of physician who	provided RU-486	Moha	munad Rez	ace M.D.
8. b. Physician's signature	— VMV Date —	8/2	0/13	
Send completed forms to:	State Medical B	oard of Ohio	1	
	Legal Department		A proper .	
	30 E. Broad St., 3 <sup>rd</sup> Floo	r	MEDIC	AL BOARD
	Columbus, OH 43215-6	5127	AUG .	2 2 2013

# report#42

#### State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provid	ed:	_ /33	27	2013
	ide. Otokin ne natrez II.a enata heze beng	Month	Day	Year
2. Name of medical practic	e or facility at whicl		vided:	
3. Address of medical pract	생산을 받는 경험에 함아되는 생각이다.	and a state of the second of the state of the		
12000 Shak	her Blud.	Chivelon	ed OH	44120
4. Date post RU-486 compli		19/13		
5. Event(s) (Please check all	that apply):			
✓ Incomplete abortion	Advers	e reaction to RU-486	Patient hospita	alized
Patient received a transfusio	nSevere bleeding			
Other serious event (specify)				
6. Duration of event:	Hours/	Days		
7. Remarks: Abortion comple	eted surgical	by on 4/	20/13, no fillection.	wther
8. a. Name of physician who	provided RU-486	Moha	muned Re	2600
8. b. Physician's signature		ote 4,24	v. 13 6	D/DO
Send completed forms to:	State Med	ical Board of Ohio	)	
	Legal Department	:		
	30 E. Broad St., 3"		MEDICAL E	BOARD
	Columbus, OH 43	215-6127	ADD 29	



(Required pursuant to R.C. 2919.123)

Month  2. Name of medical practice or facility at which RU-486 was provided:  Address of medical practice or facility at which RU-486 was provided:  12000 Shaker Blvd. Cleveland Di  4. Date post RU-486 complication began:  1/2/13  5. Event(s) (Please check all that apply):	Day	2012 Year
12000 Shaker Blvd. Cleveland De 1. Date post RU-486 complication began: 1/2/13		real
1. Date post RU-486 complication began: 1/2/13		
1/2/13	H 441	20
5. Event(s) (Please check all that apply):		
Incomplete abortion Adverse reaction to RU-486 Pa	tient hospitalized	d
Patient received a transfusion Severe bleeding		
Other serious event (specify)		
5. Duration of event: 4 Hours 7 Days		
7. Remarks: Albortion completed Surgically on 1/9/	13, no 4	wither dication.
B. a. Name of physician who provided RU-486 Mohammad	d Rezac	·e
B. b. Physician's signature  Date	2/13	D.O
end completed forms to: State Medical Board of Ohio		
Legal Department	MEDIC	AL BOARD
30 E. Broad St., 3 <sup>rd</sup> Floor Columbus, OH 43215-6127		28 2013