

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

| 1. Date RU-486 was provided: | | 09 | 24 | 15 |
|--|-----------------------------------|----------------|---------------------|-------------|
| , | | Month | Day | Year |
| 2. Name of medical practice or fa | acility at which RU- | 486 was provi | ded: | |
| 3. Address of medical practice or 12000 Shaker Bl | | | | |
| 4. Date post RU-486 complication | began: 10/10/15 | 5 | | |
| 5. Event(s) (Please check all that a | apply): | | | |
| Incomplete abortion | Adverse reac | tion to RU-486 | Patient hospitalize | d . |
| Patient received a transfusion | Severe bleeding | | | |
| Other serious event (specify) | · | | | |
| 6. Duration of event: | HoursD | ays | | |
| 7. Remarks: | eted surgical | 26y. | | |
| 8. a. Name of physician who prov 8. b. Physician's signature — | ided RU-486 | Mitch. | ell Reider | M.D. |
| Send completed forms to: | State Medical B | oard of Ohio | | |
| Lega | l Department | | | |
| 30 E | . Broad St., 3 rd Floo | r | | |
| Colu | mbus. OH 43215-6 | 5127 | ME | 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 a | it which RU-486 was provid | ded: | |
| 3. Address of medical practice or facility | at which RU-486 was prov | rided: | |
| 12,000 Shaker Blvd. | Cleveland 44 | 120 | |
| 4. Date post RU-486 complication began | 10/01/15 | | |
| 5. Event(s) (Please check all that apply): Incomplete abortion | _Adverse reaction to RU-486 | Patient hospitaliz | ed . |
| Patient received a transfusion Severe | bleeding | | |
| Other serious event (specify) | • | | |
| 6. Duration of event: 2 Hours | Days | | |
| 7. Remarks: Abortion complete | el sugically. | | |
| 8. a. Name of physician who provided R 8. b. Physician's signature | Date 10/10/1 | hell Reide |) DO |
| Send completed forms to: Star | te Medical Board of Ohio | | |
| Legal Depa | ortment | | |
| 30 E. Broad | d St., 3 rd Floor | | |
| Columbus. | OH 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 provided: | 06 | 16 | 15 |
|--|----------------------------|---------------------|----------|
| | Month | Day | Year |
| 2. Name of medical practice or facility at | t which RU-486 was provid | ed: | |
| 3. Address of medical practice or facility | at which RU-486 was provi | ided: | |
| 12000 Sheker Blad. | Cleveland | 44120 | |
| 4. Date post RU-486 complication began: | 1/10/15 | | · |
| 5. Event(s) (Please check all that apply): | | | |
| Incomplete abortion | Adverse reaction to RU-486 | Patient hospitalize | d |
| Patient received a transfusion Severe b | leeding | | |
| Other serious event (specify) | | | |
| 6. Duration of event: 2.5 Hours | Days | | |
| 7. Remarks: | | | |
| Abortion complete | d sugically. | | |
| 8. a. Name of physician who provided RU | J-486 Mohan | mad Roze | Rec |
| 8. b. Physician's signature | Date | 1/15 | D.O |
| Send completed forms to: State | e Medical Board of Ohio | | |
| Legal Depar | tment | | |
| 30 E. Broad | St., 3 rd Floor | | - TO LAR |
| Columbus, (| OH 43215-6127 | MEDICAL | L BOARD |

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 provid | ded: | 06 | 10 | 15 |
|--------------------------------|---------------------|--------------------------|---------------------|------|
| | | Month | Day | Year |
| 2. Name of medical practic | ce or facility at w | hich RU-486 was prov | ided: | |
| 3. Address of medical pract | tice or facility at | which RU-486 was pro | vided: | |
| 12000 Shakes | | | | |
| 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: | 2 Hours | Days | | |
| 7. Remarks: | n. slalal | Guraically. | | |
| Abortion ce | odpicion | out and | | |
| 8. a. Name of physician wh | o provided RV4 | 186 Mis | thell Rica | ler |
| 8. b. Physician's signature | | Date 7/ | 16/15 | D.O |
| Send completed forms to: | State N | Medical Board of Ohio | | |
| | Legal Departm | nent | | |
| | 30 E. Broad St | ., 3 rd Floor | MEDICAL BO | OARD |
| | Columbus, OH | 43215-6127 | | |
| | | | JUL 20 20 |)15 |



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

| 1. Date RU-486 was provided | d: | 06 | // | 15 |
|---------------------------------|------------------|---------------------------|--------------------|--------------|
| | | Month | Day | Year |
| 2. Name of medical practice | or facility at | which RU-486 was provid | led: | |
| 3. Address of medical practic | e or facility at | t which RU-486 was prov | ided: | |
| 12000 Shaker | Blud. | Cliveland | 44120 | |
| 4. Date post RU-486 complica | ation began: | 1/1/15 | • | |
| 5. Event(s) (Please check all t | hat apply): | 7 7 . | | - |
| Incomplete abortion | A | dverse reaction to RU-486 | Patient hospitaliz | ed . |
| Patient received a transfusion | Severe ble | eding | | |
| Other serious event (specify) _ | | | | |
| 6. Duration of event: | Hours | Days | | |
| 7. Remarks: Abortion u | ompleted | Swgically. | | |
| 8. a. Name of physician who p | provided/RU- | 486 Mite | Lell Reid | er |
| 8. b. Physician's signature | | Date 7/16/15 | MO | / D.O |
| Send completed forms to: | State | Medical Board of Ohio | | |
| | Legal Departr | ment | | |
| | 30 E. Broad S | t., 3 rd Floor | | |
| | Columbus, Ol | H 43215-6127 | M | EDICAL ROADD |

JUL 20 2015



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

| 1. Date RU-486 was provid | ed: | 05 | 06 | 2015 |
|--------------------------------------|----------------------------------|----------------------|--------------------|------------|
| | | Month | Day | Year |
| 2. Name of medical practice Areferm | e or facility at which | n RU-486 was provi | ded: | |
| 3. Address of medical practi | 아니는 아이는 아이를 가는 것이 없었다. 그렇게 하지 않 | | | |
| 4. Date post RU-486 compli | cation began: | | | |
| 5. Event(s) (Please check all | 1.1 | | | |
| Incomplete abortion | Adverse | e reaction to RU-486 | Patient hospitaliz | ed . |
| Patient received a transfusio | n Severe bleeding | | | |
| Other serious event (specify) | | • | - | |
| 6. Duration of event: | 2Hours | Days | | |
| 7. Remarks: | completed: | surgically. | | • |
| 8. a. Name of physician who | provided RU-486 | Moha | muncel PG2 | ace M.D. |
| 8. b. Physician's signature | 1,1110 | ite in the | 12/15 80 |)no |
| Send completed forms to: | State Med | ical Board of Ohio | , | |
| -,1 | Legal Department | | | * |
| | 30 E. Broad St., 3 ^{re} | Floor | 3.000 | |
| | Columbus, OH 43 | 215-6127 | MED | ICAL BOARD |

JUN 5 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 provid | led: | 03 | 12 | 15 |
|--------------------------------|------------------------------------|-------------------|---------------------|-------|
| | | Month | Day | Year |
| 2. Name of medical practic | ce or facility at which R | U-486 was provi | ded: | |
| 3. Address of medical prac | tice or facility at which | RU-486 was prov | vided: | |
| 12000 Sha | Let Blvd. | Clevelon | d 4412 | D |
| 4. Date post RU-486 compl | ication bogan | /28/15 | | |
| 5. Event(s) (Please check a | Il that apply): | 1. | | |
| Incomplete abortion | Adverse re | eaction to RU-486 | Patient hospitalize | d . |
| Patient received a transfusion | on Severe bleeding | | | |
| Other serious event (specify | | • | | |
| 6. Duration of event: | Hours | _ Days | | |
| 7. Remarks: | completed su | rgically. | | |
| 8. a. Name of physician wh | o provided RU-486 | Lisa | Pertiera | |
| 8. b. Physician's signature | Date | 4/14/1 | (MO) | D.O |
| Send completed forms to: | State Medica | al Board of Ohio | | |
| | Legal Department | | | * |
| | 30 E. Broad St., 3 rd F | loor | MEDICAL | BOARD |
| | Columbus, OH 4321 | 5-6127 | 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: | | 03 | 10 | 15 |
|---------------------------------------|-------------------------------|------------------|-----------------|--------|
| | | Month | Day | Year |
| 2. Name of medical practice or faci | lity at which R | U-486 was provi | ded: | |
| 3. Address of medical practice or fa | cility at which | RU-486 was prov | vided: | |
| 12000 Shaker & | 3lvd. | Clevela | nd " | 14120 |
| 4. Date post RU-486 complication b | | 03/15 | | |
| 5. Event(s) (Please check all that ap | | 1 | | |
| Incomplete abortion | Adverse re | action to RU-486 | Patient hospita | ized |
| Patient received a transfusion Se | evere bleeding | | | |
| Other serious event (specify) | | | | |
| 6. Duration of event: 3 H | ours | _ Days | | |
| 7. Remarks: | Heted su | gicelly. | | |
| 8. a. Name of physician who provid | ed RU-486 | Moha | mmed Re | zall |
| 8. b. Physician's signature | Date | /12 res | rel Mi |)00 |
| Send completed forms to: | State Medica | Board of Ohio | | |
| | Department | | | |
| 30 E. E | Broad St., 3 rd Fl | oor | MEDICAL | BOARD |
| Colum | bus, OH 4321 | 5-6127 | APR 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 | 22 | 15 |
|--|--|---------------------|------|
| | Month | Day | Year |
| 2. Name of medical practice or facility Preterm | y at which RU-486 was prov | rided: | |
| 3. Address of medical practice or facili | ty at which RU-486 was pro | ovided: | |
| 12000 Shaker Blv | d. Clevelan | d 441: | 20 |
| 4. Date post RU-486 complication beg | | | |
| 5. Event(s) (Please check all that apply | y): (| | |
| Incomplete abortion | Adverse reaction to RU-486 | Patient hospitalize | ed . |
| Patient received a transfusion Sever | re bleeding | | |
| Other serious event (specify) | | | |
| 6. Duration of event: Hou | rs Days | | |
| 7. Remarks: | uplated surgical | 20g. | |
| 8. a. Name of physician who provided | RU-486 | a Petriesa | |
| 8. b. Physician's signature | Date 4 06 | M.D. | /D.O |
| Send completed forms to: S | tate Medical Board of Ohio | | |
| | partment | | |
| | partment pad St., 3 rd Floor | | |
| | us, OH 43215-6127 | MEDICAL DO | ADD |
| Columbia | 0,011 10220 0221 | MEDICAL BO | JAKD |

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: | 01 | 21 | 2015 |
|---|--------------------------|---------------------|------|
| | Month | Day | Year |
| 2. Name of medical practice or facility at v | which RU-486 was pr | rovided: | |
| 3. Address of medical practice or facility at | which RU-486 was p | provided: | |
| 12000 Shaker Blvd. | Cleveland | 44120 | |
| 4. Date post RU-486 complication began: 02/06/15 | | | |
| 5. Event(s) (Please check all that apply): | • | | |
| | dverse reaction to RU-48 | Patient hospitalize | ed |
| Patient received a transfusion Severe ble | eding | | |
| Other serious event (specify) | | | |
| 6. Duration of event: Hours | Days | | |
| 7. Remarks: Abortion completed | surgically. | | |
| 8. a. Name of physician who provided RU-8. b. Physician's signature | LATE | Hell Reide |)n.o |
| Send completed forms to: State Legal Departr 30 E. Broad S | | MEDICAL BO | ARD |

Columbus, OH 43215-6127

FEB 2 0 2015

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