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: 09 (Month) 24 (Day) 15 (Year)

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

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: 10/10/15

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: 2 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 _____ (M.D. / D.O)

Date 10/16/15

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

MEDICAL BOARD
OCT 19 2015

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

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: 09 (Month) 10 (Day) 15 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
12,000 Shaker Blvd. Cleveland 44120

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 hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 2 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 _____ M.D. / D.O.

Date 10/10/15

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

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

MEDICAL BOARD
OCT 15 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: 06 (Month) 16 (Day) 15 (Year)

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

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:
7/10/15

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: 2.5 Hours _____ Days

7. Remarks:
Abortion completed surgically.

8. a. Name of physician who provided RU-486 Mohammad Rezaee

8. b. Physician's signature _____ (M.D. / D.O.)

Date 7/14/15

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

MEDICAL BOARD
JUL 20 2015

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

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: 06 (Month) 10 (Day) 15 (Year)

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

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:
7/3/15

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: 2 Hours _____ Days

7. Remarks:
Abortion completed surgically.

8. a. Name of physician who provided RU-486 Mitchell Rider

8. b. Physician's signature _____ (M.D./D.O.)

Date 7/16/15

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

MEDICAL BOARD
JUL 20 2015

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

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: 06 (Month) 11 (Day) 15 (Year)

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

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:
7/7/15

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: 2 Hours _____ Days

7. Remarks:
Abortion completed Surgically

8. a. Name of physician who provided RU-486 Mitchell Reider

8. b. Physician's signature _____ M.D. / D.O

Date 7/16/15

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

MEDICAL BOARD
JUL 20 2015

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

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: 05 (Month) 06 (Day) 2015 (Year)

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

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:
6/2/15

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: 2 Hours _____ Days

7. Remarks:
Abortion completed surgically.

8. a. Name of physician who provided RU-486 Mohammed Grace, M.D.

8. b. Physician's signature [signature] M.D / D.O

Date 6/2/15

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

MEDICAL BOARD
JUN 5 2015

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

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 (Month) 12 (Day) 15 (Year)

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

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: 03/28/15

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: 2 Hours _____ Days

7. Remarks:
Abortion completed surgically.

8. a. Name of physician who provided RU-486 Lisa Periera

8. b. Physician's signature _____ M.D./D.O.

Date 4/16/15

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

MEDICAL BOARD
APR 20 2015

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

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 (Month) 10 (Day) 15 (Year)

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

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: 04/03/15

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 Mohammad Rezaee

8. b. Physician's signature [signature] (M.D. / D.O)

Date 4/14/15

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

MEDICAL BOARD
APR 20 2015

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

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: 01 (Month) 22 (Day) 15 (Year)

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

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:
2/13/15

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: 2 Hours _____ Days

7. Remarks:
Abortion completed surgically.

8. a. Name of physician who provided RU-486 Lisa Derrico

8. b. Physician's signature _____ M.D./D.O.

Date 2/26/15

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

MEDICAL BOARD
MAR 2 2015

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

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: 01 (Month) 21 (Day) 2015 (Year)

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

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:
02/06/15

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: 2 Hours _____ Days

7. Remarks:
Abortion completed surgically.

8. a. Name of physician who provided RU-486 Mitchell Reider

8. b. Physician's signature _____ (M.D.) D.O.

Date 2/18/15

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

MEDICAL BOARD
FEB 20 2015

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