

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provide	·q.	10	201	W.
2. Date NO 400 Was provide		Month	Day	Year
2. Name of medical practice	e or facility at which			real
3. Address of medical practic			,	
12000 Sha	her Wiva.	Clevela	wa 941	20
4. Date post RU-486 complic	ation began:			
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:	empleted sw	gially.		;
8. a. Name of physician who 8. b. Physician's signature	provided RU-486	CV relief	unod Roza	
Send completed forms to:	State Medi	cal Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd	Floor		
	Columbus, OH 432			-

MEDICAL BOARD

NOV 2 0 2014



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provid	ded:	10	23	14
		Month	Day	Year
2. Name of medical practic	ce or facility at which F	U-486 was provid	ded:	
3. Address of medical pract			rided:	
12000 Shaker	Blvd. Cla	ve. OH	44120	
4. Date post RU-486 compl	ication began:			., ø
5. Event(s) (Please check al	I that apply):			TATE OF TATE
Incomplete abortion		eaction to RU-486	Patient hospitalized	ZOJI NOV 18
Patient received a transfusion	on Severe bleeding			AL BOARD AM 10: 08
Other serious event (specify)			^{&} ~
6. Duration of event:	2 Hours	_ Days		
7. Remarks: Abortion Ca	supleted sur	gially.		
8. a. Name of physician wh 8. b. Physician's signature	() ITT	1/14/14	Derviera MD/DA	0
Send completed forms to:	State Medica	l Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd F	loor		
	Columbus, OH 4321	5-6127		



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provid	ed:	08	28	14
		Month	Day	Year
2. Name of medical practic	e or facility at wh	ich RU-486 was provid	ded:	
3. Address of medical pract	ice or facility at w	hich RU-486 was prov	vided:	
12000 Shaki	er Blvd.	Cleveland	44120	
4. Date post RU-486 compli		09/12/14		
5. Event(s) (Please check al	that apply):	1 1.		
Incomplete abortion	Adve	erse reaction to RU-486	Patient hospitalized	
Patient received a transfusio	n Severe bleedi	ing		
Other serious event (specify)			
6. Duration of event:	Hours	Days		
7. Remarks:	completa	ed surgically	<i>y</i> .	
8. a. Name of physician who	provided Ry-48	6 Lisa	Retriera	
8. b. Physician's signature	XIF.	9/19	MD/D	0
		Date		
Send completed forms to:		edical Board of Ohio		,
	Legal Departme 30 E. Broad St.,			
	Columbus, OH		MEDICAL BOA	RD
			SEP 2 2 2014	



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	07	03	14
	Month	Day	Year
2. Name of medical practice or facility at w	rhich RU-486 was provide	ed:	
3. Address of medical practice or facility at [2000 Shaker Blvd.	which RU-486 was provi	ded:	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):	•		
Ad	verse reaction to RU-486 _	Patient hospitalize	ed .
Patient received a transfusion Severe blee	ding		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:			
Abortion competed su	rgically.		r n
8. a. Name of physician who provided RU/4	Date 8/8/19	Aerrica /	10.0
Send completed forms to: State N	Medical Board of Ohio		

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	Dh	Az	101
	Month	Day	Year
2. Name of medical practice or facility a			real
3. Address of medical practice or facility	at which RU-486 was pro	vided:	
4. Date post RU-486 complication began);	44120	
5. Event(s) (Please check all that apply):	11		
Incomplete abortion	_Adverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe	bleeding		
Other serious event (specify)			
6. Duration of event: Hours			
7. Remarks: Abortion completed surg	ically.		•
8. a. Name of physician who provided R	U-486 Mohan	uncel Rezere,	и.б.
8. b. Physician's signature	Juz	MD/D	.0
	Date7	19/14	
Send completed forms to: Sta	te Medical Board of Ohio	1	
Legal Depa	rtment		
30 E. Broad	St., 3 rd Floor	MEDICAL B	OARD
Columbus,	OH 43215-6127	JUL 142	014