



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:	<u>10</u>	<u>08</u>	<u>14</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Artem</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Mohammed Rezaei</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD</u> <u>D.O.</u>			
Date <u>10/16/14</u>			

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

MEDICAL BOARD



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To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	
<u>10</u> Month	<u>23</u> Day
<u>14</u> Year	
2. Name of medical practice or facility at which RU-486 was provided: <u>Proform</u>	
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleve. OH 44120</u>	
4. Date post RU-486 complication began: <u>11/8/14</u>	
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____	
6. Duration of event: <u>2</u> Hours _____ Days	
7. Remarks: <u>Abortion completed surgically.</u>	
8. a. Name of physician who provided RU-486 <u>Lisa Ferreira</u>	
8. b. Physician's signature <u>[Signature]</u> <u>M.D./D.O.</u>	
Date <u>11/14/14</u>	

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1. Date RU-486 was provided:	<u>08</u>	<u>28</u>	<u>14</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>09/12/14</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>4</u> Hours _____ Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Lisa Ferreira</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>9/19/14</u>			

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SEP 22 2014



State Medical Board of Ohio Report of RU-486 Event

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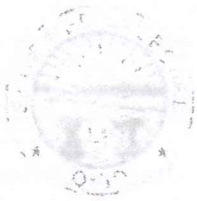
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>07</u>	<u>03</u>	<u>14</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Proform</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd.</u>			
4. Date post RU-486 complication began: <u>8/2/14</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>1</u> Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Lisa Ventura</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O.			
Date <u>8/8/14</u>			

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State Medical Board of Ohio Report of RU-486 Event

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To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>06</u>	<u>03</u>	<u>14</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland 44120</u>			
4. Date post RU-486 complication began: <u>06/20/14</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>1</u> Days			
7. Remarks: <u>Abortion completed surgically.</u>			
8. a. Name of physician who provided RU-486 <u>Mohammad Rezaee, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> <u>M.D./D.O.</u>			
Date <u>7/9/14</u>			

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