(Required pursuant to R.C. 2919.123)

1. Date RU-486 was prov	ided:	<i>72</i>	0/	17
		Month	Day	Year
2. Name of medical pract	ice or facility at which RU	-486 was provid	led:	
3. Address of medical prac	ctice or facility at which R	U-486 was prov	ided:	
12000 Shak	er Blvd. Cla	reland	44120	
4. Date post RU-486 comp				
5. Event(s) (Please check a	Il that apply):			
Incomplete abortion	Adverse read	ction to RU-486	Patient hospitalized	•
Patient received a transfusi	on Severe bleeding			
Other serious event (specify	· /)			
6. Duration of event:	,Hours[Days		
7. Remarks:				
8. a. Name of physician wh	o provided RU-486	Mitchel	Pleider, M.	D.
8. b. Physician's signature			MD/D	0
	Date —	- 3/25/1	7	
Send completed forms to:	State Medical B	oard of Ohio		
	Legal Department			ARD.
	30 E. Broad St., 3 rd Floo		MEDICAL BO	
	Columbus, OH 43215-6	5127	MAR 01 201	7

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provid	led:	02	24	17
		Month	Day	Year
2. Name of medical practice Preferm	ce or facility at which	RU-486 was provi	ded:	
3. Address of medical pract 1200 She Kel 4. Date post RU-486 compl 310/17 5. Event(s) (Please check al	- Blvd C ication began:	,		
Incomplete abortion Patient received a transfusion Other serious event (specify	on Severe bleeding		Patient hospitalized	
6. Duration of event:	Hours	Days		
7. Remarks:			. 3	
8. a. Name of physician who	o provided RU-486	Mita	4/1/17 (Gide	1, M.D.
Send completed forms to:	Legal Department 30 E. Broad St., 3 rd F			- N ROARD
	Columbus, OH 432:	15-6127	MEDI	CAL BOARD AR 1 5 2017

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:	23	07	17
	N	onth	Day	Year
2. Name of medical praction	ce or facility at which RU-48	5 was provided	d:	
3. Address of medical pract	tice or facility at which RU-4	86 was provid	ed:	
12000 SheKer	- Blud. Clave	and	44120	
4. Date post RU-486 compl 03/1 を	-			
5. Event(s) (Please check al	that apply):	•		
Incomplete abortion	Adverse reaction	to RU-486	_ Patient hospitalized	
Patient received a transfusion	on Severe bleeding			via.
Other serious event (specify)		•		
6. Duration of event: 2	Hours Days	3		
7. Remarks:				
			······································	
8. a. Name of physician who	provided RU-486	Monis	u Katsuk,	", M.D.
8. b. Physician's signature	MAdele	COH	MD/I	٠٠
	Date	3/21	117	
Send completed forms to:	State Medical Boar	d of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd Floor	ه نام به نخسیستان از	LDOADD	
	Columbus, OH 43215-612	₇ MEDICA	J. BOARD	
		MÁR	2 4 2017	

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

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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:	az	14	17
	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	at which RU-486 was pr	ovided:	
12000 Shoker Bli	id. Cleve	44120	
4. Date post RU-486 complication began:	03/15/17		
5. Event(s) (Please check all that apply):	/ / /		
Incomplete abortion	Adverse reaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion Severe b	oleeding		·
Other serious event (specify)		•	
6. Duration of event: Hours	Days		
7. Remarks:			
		. 1/1 //	//
8. a. Name of physician who provided R	U-486 <u>Mour</u>	ique Kotsuk	, U.S.
8. b. Physician's signature	Date 3/28/1	7 <u>(M.D.</u>	<u> 4 n.o</u>
Send completed forms to: Stat	te Medical Board of Ohi	0	
Legal Depa	rtment		
30 E. Broad	d St., 3 rd Floor		

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

Columbus, OH 43215-6127

MEDICAL BOARD

APR 0 3 2017

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	03	24	
	Month	Day	Year
2. Name of medical practice or facility at	which RU-486 was provide	ed:	
3. Address of medical practice or facility	at which RU-486 was provi	ded:	
12000 Shoker Blud	. Cleveland	44120	
12000 Sheker Blvd. 4. Date post RU-486 complication began	3/24/17		
5. Event(s) (Please check all that apply):			•
Incomplete abortion	Adverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe t	pleeding		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:			
		7 /	
8. a. Name of physician who provided	14-486 . Mitchel	M. Rider	<i>U</i> .D
8. b. Physician's signature	pate 3/	. <u>(MD/</u> 31/17	D.O
Send completed forms to: Sta	te Medical Board of Ohio		
Legal Depa	artment		
30 E. Broa	d St., 3 rd Floor		
Columbus	OH 43215-6127	MEDICAL	BOARD

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

APR 0 3 2017

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provid	ed:	<u> 194</u>	12	
		Month	Day	Year
2. Name of medical practic	e or facility at wh	ich RU-486 was prov	ided:	
Preterm	e te			
		1 · 1 · D.11 · A.0.5 · · · · · · · · · · · · · · · · · · ·	idad.	
3. Address of medical pract				
12000 Shaker	- Blud.	Cleveland	44120	>
4. Date post RU-486 compli	cation began:			
5. Event(s) (Please check all	that apply):			
Incomplete abortion	Adv	erse reaction to RU-486	Patient hospital	ized
Patient received a transfusio	n Severe bleed	ing		
Other serious event (specify				
6. Duration of event:	Hours	Days		
7. Remarks:				
8. a. Name of physician wh	o provided RU-4	86 Mila	anned Re	1600 M.D.
	2	Wilsen	~ m = 1) . '
8. b. Physician's signature		CICE STE	1/1/17	2/0.0
		Date	3/0///	
Send completed forms to:	State IV	ledical Board of Ohio		
	Legal Departm	ent		
	30 E. Broad St.	, 3 rd Floor		
	Columbus, OH	43215-6127	MED	ICAL BOARD
			٨	MAY 1 2 2017

Prescribed: 5/--/2041, 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 provide	d:	06	17	
		Month	Day	Year
2. Name of medical practice Areterm	or facility at which I	RU-486 was prov	vided:	
3. Address of medical practic	e or facility at which	n RU-486 was pr	ovided:	
12000 Shaker 4. Date post RU-486 complic	ation began:		44120	
5. Event(s) (Please check all		reaction to RU-486	Patient hospitalized	•
Patient received a transfusion	Severe bleeding			
Other serious event (specify)				
6. Duration of event:	/Hours	Days		
7. Remarks:		and the second s		
			100 6 0	
8. a. Name of physician who	provided RU-486 Dat	te	7/12/17 MD/	/
Send completed forms to:	State Medi	cal Board of Ohi	0	
	Legal Department			
	30 E. Broad St., 3 rd	Floor		
	Columbus, OH 432	215-6127	MEDICAL	BOARD
			JUL 1 7	2017

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

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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 provid	led:	08	15	17
		Month	Day	Year
2. Name of medical practic	ce or facility at which	RU-486 was provic	led:	
3. Address of medical pract	tice or facility at whic	h RU-486 was prov	ided:	
12000 Shaker	Blvd.	Cleveland	44120	
4. Date post RU-486 compl				
5. Event(s) (Please check al	I that apply):			
Incomplete abortion	Adverse	reaction to RU-486	Patient hospitalized	•
Patient received a transfusion	on Severe bleeding			
Other serious event (specify		•	-	
6. Duration of event:	2 Hours	Days		
7. Remarks:				
8. a. Name of physician wh	o provided RU-486	Moniga	e KatsuKi,	u,D.
8. b. Physician's signature		Ja (CAD)	(17) MD/1	<u></u>
Send completed forms to:		cal Board of Ohio		
·	Legal Department			
	30 E. Broad St., 3 ^{rc}	Floor		
	Columbus, OH 432		MEDIC	AL BOARD
			SEP	1 4 2017

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:	08	16	17
	Month	Day	Year
2. Name of medical practice or facility at v	vhich RU-486 was p	rovided:	
3. Address of medical practice or facility at	which RU-486 was	provided:	
12000 Staker Blvd.	Cleveland	44120)
4. Date post RU-486 complication began:	09/12/17		
5. Event(s) (Please check all that apply):			
Incomplete abortion Ad	verse reaction to RU-48	6 Patient hospitali:	zed .
Patient received a transfusion Severe blee	ding		
Other serious event (specify)			
6. Duration of event: 4 Hours	Days		
7. Remarks:			
			•
8. a. Name of physician who provided RU-4	06 1 11	1120 6.1	// 5
8. b. Physician's signature	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	tine Reide	1, 10.1).
B. D. Physician's Signature	Date	9/14/17	/ D.O
Send completed forms to: State M	iedical Board of Ohi	0	
Legal Departme	ent		
30 E. Broad St.,	3 rd Floor		
Columbus, OH	43215-6127		

MEDICAL PORRE

SEP 2 0 2017

(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provide	ed:	09	22	17
		Month	Day	Year
2. Name of medical practice Areterm	e or facility at whic	h RU-486 was pro	ovided:	
3. Address of medical practi	ce or facility at wh	ich RU-486 was p	rovided:	
12000 Sheker	Blvd.	Cleve.	44120	
4. Date post RU-486 compli	cation began:			
5. Event(s) (Please check all	that apply):			
			postore boundaries	
Incomplete abortion	Adver	rse reaction to RU-48	6 Patient hospitali	
Patient received a transfusio	n Severe bleedir	ig .		
	•			
Other serious event (specify)				
	1	Davis		
6. Duration of event:	Hours	Days		
7. Remarks:				
7. Nemarks.				
	idad DIIMO	6 M	chell Rider	M.D.
8. a. Name of physician wh	o provided No.78		Chief 14 told	
8. b. Physician's signature	-	NY	MI (M)	<u> </u>
	()	Date 10	20/17	
Send completed forms to:	State Me	edical Board of Ol	nio	
•	Legal Departme	ent	*	
	30 E. Broad St.,		MEDI	CAL BOARD
	Columbus, OH	4771 C477	nr	

(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provid	led:	10	10	2017
		Month	Day	Year
2. Name of medical practice Preterm	ce or facility at which RU	-486 was pro	vided:	
3. Address of medical pract	ice or facility at which R	U-486 was pr	ovided:	
12000 Shake	r Blud. Cleve	land, oh	io 44120)
4. Date post RU-486 compl	ication began:			
5. Event(s) (Please check al	I that apply):			
Incomplete abortion	Adverse rea	ction to RU-486	Patient hospitali	zed .
Patient received a transfusic	on Severe bleeding			
Other serious event (specify				<u> </u>
6. Duration of event:	Hours	Days		
7. Remarks:				
8. a. Name of physician who	provided RU-486	Monique	2 Katsuki,	MD
8. b. Physician's signature	MI	Indix	Ch (MR	/D.O
	Date _	11/14	1117	
Send completed forms to:	State Medical I	Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd Flo	or	Ž	VIEDS AN BOAR
	Columbus, OH 43215-	6127		MON RA 2017

(Required pursuant to R.C. 2919.123)

1. Date RU-486 was prov	vided:	10	PG	2017
		Month	Day	Year
2. Name of medical practi Preterm	tice or facility at which RU-4	186 was prov	vided:	
3. Address of medical pra	ctice or facility at which RU	-486 was pro	ovided:	
12000 Shaker	Blvd Cleveland	ohio	44120	
4. Date post RU-486 comp				
5. Event(s) (Please check a	all that apply):			
✓ Incomplete abortion	Adverse reacti	on to RU-486	Patient hospitalized	
Patient received a transfus	ion Severe bleeding			
Other serious event (specif	у)	_		
6. Duration of event:	9 Hours Da	ıys		
7. Remarks:				
R a Namo of physician wh	i day 6	N' \-0\ .	11 00:100	
3. a. Name of physician wh 3. b. Physician's signature	no provided RU7486	Mitche		ND
signature	Date)	12/1/17	0.0
end completed forms to:	State Wedical Bo	ard of Ohio		
	Legal Department		1.71-1.	of Styles
	30 E. Broad St., 3 rd Floor			
	Columbus, OH 43215-61	27	5.1	FC 6 & 2017

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was prov	ided:	10	28	2017
		Month	Day	Year
2. Name of medical pract	ice or facility at which	RU-486 was prov	rided:	
3. Address of medical prac	tice or facility at which	n RU-486 was pro	ovided:	
12000 Shak)
4. Date post RU-486 comp				
5. Event(s) (Please check a	ll that apply):			
Incomplete abortion	Adverse r	eaction to RU-486	Patient hospitalize	d
Patient received a transfusio	on Severe bleeding	•		
Other serious event (specify				·
. Duration of event:	Hours	Days		
. Remarks:				
a. Name of physician who	provided RU-486	Justin	Lappen, N	(D
b. Physician's signature		MOIN		0.0
	Date	12/2/17		
nd completed forms to:	State Medical	Board of Ohio		
	Legal Department	-		
	30 E. Broad St., 3 rd Flo	oor		
	Columbus, OH 43215			

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

3

DEC 0 7 201/

(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	2017
		Month	Day	Year
2. Name of medical praction Protection	ce or facility at which I	RU-486 was prov	ided:	
3. Address of medical pract	ice or facility at which	DII 196 was pro	vid ad.	
		· · · · · · · · · · · · · · · ·		
12000 Shaker	BIVD Clei	relugio o	04 44120	
4. Date post RU-486 compl	ication began:	a de la granda de de la filosoficia de		
111717017				
5. Event(s) (Please check al	I that apply):	•		
Incomplete abortion	Adverse re	eaction to RU-486	Patient hospitalized	
Patient received a transfusio	n Severe bleeding	•		
Other serious event (specify)				·
6. Duration of event: _ 3	Hours	_ Days		
7. Remarks:				
3. a. Name of physician who	provided RU-486	Justin	-appen, MD	
3. b. Physician's signature	Date		PPA MD/DO)
send completed forms to:	<u> </u>			
ena completen forms (0:		Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd Flo			
	Columbus, OH 43215	o-b12/	MED	ICAL BOARI

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

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DEC 0 7 2017