(Required pursuant to R.C. 2919.123)

1. Date RU-486 was prov	vided:	61	05	2018
		Month	Day	Year
2. Name of medical prac	tice or facility at which			
3. Address of medical pra	ectice or facility at which	n RU-486 was pr	ovided:	
12000 Shak				20
4. Date post RU-486 comp	plication began:			
5. Event(s) (Please check a	all that apply):			
Incomplete abortion	Adverse r	eaction to RU-486	Patient hospitalia	zed
Patient received a transfus	ion Severe bleeding			
Other serious event (specif	ý)			
6. Duration of event:	3Hours	_ Days		
7. Remarks:				
8. a. Name of physician wh	no provided RU 486	~ W.F	h Reider, u	nD
8. b. Physician's signature	<u> </u>		M.D.,	/00
	Date	2	.9.18	
Send completed forms to:	State Medica	Board of Ohio		
	Legal Department .			
	30 E. Broad St., 3 <sup>rd</sup> Fl		MEDICA	L BOARD
	Columbus, OH 4321	5-6127	EED .	1 5 2018

(Required pursuant to R.C. 2919.123)

1. Date RU-486 was prov	ided:	01	26	2018
		Month	Day	Year
	ice or facility at which RU-	486 was pro	vided:	
Preferm		da da la servez e pedi e hi da esta di la dia.	atti ali ole	na tida da na za za naprantina, kida dibenja da dika a dike.
3. Address of medical prac	ctice or facility at which RU	J-486 was pr	ovided:	
12000 Sha	aker Blvd.	Cleve	land, OH	44120
4. Date post RU-486 comp	lication began:		,	
5. Event(s) (Please check a	ill that apply):			3
Incomplete abortion	Adverse react	ion to RU-486	Patient hospitalize	ed
Patient received a transfusi	on Severe bleeding			
Other serious event (specify	γ)		-	<del></del>
6. Duration of event:	<b>)</b> Hours Da	ays		
7. Remarks:				
	$\wedge$			
8. a. Name of physician wh	o provided RIL-186 A	Mitch	n Reider,	mì
	o provided no 400		1 (VETOCI)	73(1)
8. b. Physician's signature	Date	2	21/18	D.O
Send completed forms to:	State Medical Bo	ard of Ohio		
	Legal Department			
	30 E. Broad St., 3 <sup>rd</sup> Floor		MED	ICAL BOARD
	Columbus, OH 43215-61	127	٢	<u>ଅଭି ବ୍ୟୁଟ୍ର</u>

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	02		3	2018
	Month		Day	Year
2. Name of medical practice or face Preferm	cility at which RU-486 wa	as provided:		
3. Address of medical practice or fa	acility at which RU-486 v	vas provided:		
12000 Shaker B	Ivd. Clevelo	ind, cH	4412	0
4. Date post RU-486 complication I		,		
5. Event(s) (Please check all that ap	oply):			
Incomplete abortion	Adverse reaction to R	U-486 Patie	nt hospitalized	·
Patient received a transfusion Se	evere bleeding			
Other serious event (specify)		•		
6. Duration of event: 3	ours Days			
7. Remarks:		A		
·				
8. a. Name of physician who provid	ed RU-486 MC	onique Ko	atsuki,	dm
8. b. Physician's signature	Mily Cord Date 3/6	20   18	/ M.D./D	.0
Send completed forms to:	State Medical Board of	Ohio		
Legal (	Department			
30 E. B	Broad St., 3 <sup>rd</sup> Floor			

Columbus, OH 43215-6127

MEDICAL BOARD

MAR : 3 2018

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	3	14	2018	
	Month	Day	Year	
2. Name of medical practice or facility a	at which RU-486 was prov	ided:		
Preterm		and the first of the second of		
3. Address of medical practice or facility	at which RU-486 was pro	vided:		
12000 Shaker Blvd.	Cleveland OH	44120		
4. Date post RU-486 complication began	1:	. 1100		
5. Event(s) (Please check all that apply):		***************************************		
Incomplete abortion	Adverse reaction to RU-486	Patient hospitali	ced	:
Patient received a transfusion Severe b	pleeding			
Other serious event (specify)				
6. Duration of event: 3 Hours	Days			
7. Remarks:				
8. a. Name of physician who provided Rt	J-486 NATALIE H	inch diffe,	<b>M</b>	
8. b. Physician's signature	Date — 4	14/18		
Send completed forms to: State	Medical Board of Ohio			<del></del>
Lega! Depart	tment			
30 E. Broad 9	St. 3 <sup>rc</sup> Floor			

Columbus, OH 43215-6127

MEDICAL BOARD

(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:		05	[5]	2018
		Month	Day	Year
2. Name of medical practice of	r facility at which R	U-486 was provi	ded:	
Preterm				
	£ . 11:4 4 L : - L	D11 40C	ين ما م ما ي	
3. Address of medical practice		· _		
12000 Shaker E	olvd. Cleve	Janu, Ot	44120	)
4. Date post RU-486 complicat				
6/5/18	_			
5. Event(s) (Please check all tha	at apply):	•		
	*		Dustrus ir sauts	
Incomplete abortion	Adverse re	eaction to RU-486	Patient nospiti	alized
Patient received a transfusion _	Severe bleeding			
Other serious event (specify)				
Other serious event (specify)				
6. Duration of event: 3		<b>5</b>		
6. Duration of event:	Hours	_ Days		
7. Remarks:				
8. a. Name of physician who pr	ovided RU-486	Moniqu	<u>e Katsuk</u>	, MD
8. b. Physician's signature		Mydul	Cot N	D./D.O
: ;	Date	- 41	12/18	
Send completed forms to:	State Medica	al Board of Ohio	The state of the s	
·	ega! Department			
	0 E. Broad St., 3 <sup>rc</sup> F	ioor		
	olumbus. OH 4321			MEDICAL BOARD
C				MEDICAL

(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:		05	29	2018			
		Month	Day	Year			
2. Name of medical practi	ce or facility at which	RU-486 was prov	vided:				
3. Address of medical prac	tice or facility at whic	h RU-486 was pro	ovided:				
12000 Shaker Blud Cleveland, OH 44120							
4. Date post RU-486 comp	lication began:						
5. Event(s) (Please check a	l that apply):	-		·			
Incomplete abortion	Adverse	reaction to RU-486	Patient hospitaliz	zed			
Patient received a transfusion Severe bleeding							
Other serious event (specify)							
6. Duration of event:	Hours <b>Q</b>	Days					
7. Remarks:							
8. a. Name of physician wh	o provided RU-486	moniqu	e Katsuki	, MD			
8. b. Physician's signature		1411/16/18/18/18/18/18/18/18/18/18/18/18/18/18/	Y (M)	/ D.O			
Send completed forms to:		al Board of Ohio					
	Legal Department						
	30 E. Broad St., 3 <sup>rd</sup>	Floor	MEDICAL B	OARD			
/	Columbus, OH 432	15-6127	JUN 26	2018			