

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>02</u>	<u>14</u>	<u>17</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. Cleve 44120</u>		
4. Date post RU-486 complication began:	<u>03/15/17</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:			
8. a. Name of physician who provided RU-486	<u>Monique Katsuki, M.D.</u>		
8. b. Physician's signature	<u>[Signature]</u>	<u>MD/DO</u>	
	Date	<u>3/28/17</u>	

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

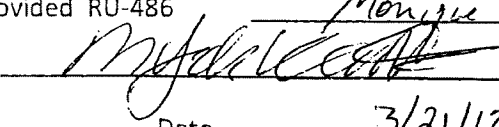
MEDICAL BOARD

APR 03 2017

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>03</u>	<u>07</u>	<u>17</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>03/18/17</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:			
8. a. Name of physician who provided RU-486	<u>Monique Katsuki, M.D.</u>		
8. b. Physician's signature	<u></u>	<u>(M.D./D.O.)</u>	
	Date	<u>3/21/17</u>	

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MEDICAL BOARD

MAR 24 2017

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>05</u>	<u>15</u>	<u>17</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Proterum</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:			
8. a. Name of physician who provided RU-486	<u>Monique Katsuki, M.D.</u>		
8. b. Physician's signature	<u>[Signature]</u>	<u>MD/DO</u>	
	Date <u>9/12/17</u>		

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MEDICAL BOARD

SEP 14 2017

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>10</u>	<u>2017</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, Ohio 44120</u>		
4. Date post RU-486 complication began:	<u>11/14/17</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>3</u>	Hours	_____ Days
7. Remarks:			
8. a. Name of physician who provided RU-486	<u>Monique Katsuki, MD</u>		
8. b. Physician's signature	<u><i>Monique Katsuki</i></u> (MD/DO)		
	Date	<u>11/14/17</u>	

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MEDICAL BOARD

NOV 24 2017