(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	01	21	2015
	Month	Day	Year
2. Name of medical practice or facility at which	RU-486 was prov	vided:	
3. Address of medical practice or facility at which	n RU-486 was pro	ovided:	
12000 Shaker Blvd. Cl	evelowel	44120	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Adverse	reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe bleeding			•
Other serious event (specify)			-
6. Duration of event: Hours	Days		
7. Remarks:			•
Abortion completed su	urgically.		
· /	4		
8. a. Name of physician who provided Ru-186	1 Mite	hell Reide	Г
8. b. Physician's signature	e z	18/15 (10)	D.O
Send completed forms to: State Medic	al Board of Ohio		

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

FEB 2 0 2015



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provide	ded:	Dle	ID.	15
		Month	Day	Year
2. Name of medical practi	ce or facility at whic	ch RU-486 was pro	vided:	
3. Address of medical prac	tice or facility at wh	nich RU-486 was pr	ovided:	
12000 Shakes	- Blod.	Cleveland	44120	
4. Date post RU-486 comp		15		
5. Event(s) (Please check a	7 1			
Incomplete abortion	Adver	se reaction to RU-486	Patient hospitalized	
Patient received a transfusion	on Severe bleedin	g		
Other serious event (specify			•	· · · · · · · · · · · · · · · · · · ·
6. Duration of event:	2 Hours	Days		
7. Remarks:				
Albertion ce	suploted ou	igially.		
8. a. Name of physician wh	o provided RU486	M	Fell Rid	er
8. b. Physician's signature		ate 7	116/15	D.O
Send completed forms to:	State Med	dical Board of Ohio) .	
,	Legal Departmen	t		:
	30 E. Broad St., 3	rd Floor		
	Columbus, OH 4	3215-6127	MEDICAL BU	
			JUL 20 20	15

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provid	ed:	06		15
. ''		Month	Day	Year
2. Name of medical practic	e or facility at w	vhich RU-486 was pro	ovided:	
3. Address of medical pract	ice or facility at	which RU-486 was p	rovided:	
12000 Shake 4. Date post RU-486 compli	+ Blud.	Clevelano	1 4412	9
4. Date post RU-486 compli	cation began:	1/2/15		
5. Event(s) (Please check all	that apply):			
Incomplete abortion	Ad	lverse reaction to RU-486	Patient hosp	italized
Patient received a transfusio	n Severe blee	eding		
Other serious event (specify)			•	
6. Duration of event:	Hours _	Days		
7. Remarks: Abortion	completed	Swgically.		,
8. a. Name of physician who 8. b. Physician's signature	provided/RU-4	186 Mi	telell K	10)10.0
Send completed forms to:	State N	/ . Medical Board of Ohio)	
	Legal Departm			<i>:</i>
	30 E. Broad St.			
	Columbus, OH	43215-6127		MEDICAL BOARD

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

JUL 2 0 2015



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided	•	09	10	15
	_	Month	Day	Year
2. Name of medical practice of the form	or facility at whic	h RU-486 was prov	ided:	
3. Address of medical practice	or facility at whi	ich RU-486 was pro	vided:	
12,000 Shaker K	iman gibi Majiya M	eveloud 40		
4. Date post RU-486 complica	tion began:	10/01/15		1
5. Event(s) (Please check all th				
Incomplete abortion	Advers	se reaction to RU-486	Patient hospitalize	:d
Patient received a transfusion	Severe bleeding			
		•		•
Other serious event (specify) _		•		
		211		
6. Duration of event:	Hours	Days		
7. Remarks:	mpleted 5	esgically.		
8. a. Name of physician who p	rovided BU-A86	Mit	Will Reide	u
1			74.00	<u> </u>
8. b. Physician's signature	Da	ate	(M.D.)	D.O
Send completed forms to:	State Med	ical Board of Ohio		
	egal Department	t	•	<i>:</i>
3	30 E. Broad St., 3 ^r	^d Floor		
C	Columbus, OH 43	215-6127		

MEDICAL BOARD

OCT 15 2015

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	led:	09		24	15
ı		Month		Day	Year
2. Name of medical practice Areter m	ce or facility a	at which RU-486 was p	orovided:		
3. Address of medical pract	ice or facility	at which RU-486 was	provided:		
12000 Staker				20	
4. Date post RU-486 compl	ication begar	10/10/15			
5. Event(s) (Please check al	I that apply):				
Incomplete abortion		_ Adverse reaction to RU-	486 <u> </u>	tient hospitaliz	ed
Patient received a transfusio	on Severe	bleeding			•
Other serious event (specify)				
6. Duration of event:	ZHours	Days			
7. Remarks:	mpleted	sing ally.			,
8. a. Name of physician who 8. b. Physician's signature	o provided R	RU-486	tchell 14/15	Reider	, M. D.
Send completed forms to:	Sta	te Medical Board of O	hio		
•	Legal Depa	artment			;
	30 E. Broad	d St., 3 rd Floor		_	
	Columbus,	OH 43215-6127		ME	EDIC-L TOARD
					OCT 19 2015

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