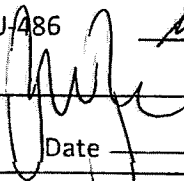


State Medical Board of Ohio Report of RU-486 Event

(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>30</u>	<u>2016</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>04/26/16</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:	<u>Abortion completed surgically.</u>		
8. a. Name of physician who provided RU-486	<u>Mitchell Reider, M.D.</u>		
8. b. Physician's signature		<u>M.D. D.O.</u>	
	Date	<u>4/27/16</u>	

Send completed forms to: State Medical Board of Ohio

Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD

MAY 2 2016



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: 04 / 29 / 16
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
Praterm

3. Address of medical practice or facility at which RU-486 was provided:
12000 Shaker Blvd. Cleveland 44120

4. Date post RU-486 complication began:
5/13/16

5. Event(s) (Please check all that apply):

Incomplete abortion Adverse reaction to RU-486 Patient hospitalized

Patient received a transfusion Severe bleeding

Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days unknown

7. Remarks:
Abortion completed surgically elsewhere.

8. a. Name of physician who provided RU-486: Mitchell Reider, M.D.

8. b. Physician's signature: [Signature] MD/DO

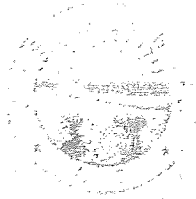
Date: 6/11/16

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MEDICAL BOARD

JUN 6 2016

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

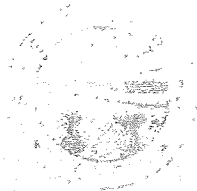
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>06</u> <u>17</u> <u>16</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>07/05/16</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>Mitchell Reider, M.D.</u>
8. b. Physician's signature	<u>[Signature]</u> <u>(M.D.) D.O.</u>
	Date <u>7/8/16</u>

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MEDICAL BOARD

JUL 12 2016



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>07</u> <u>30</u> <u>16</u> <small>Month Day Year</small>
2. Name of medical practice or facility at which RU-486 was provided:	<u>Arctorn</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>08/13/16</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>1</u> Hours _____ Days
7. Remarks:	
8. a. Name of physician who provided RU-486	<u>Mitchell Reider, M.D.</u>
8. b. Physician's signature	_____
Date	<u>8/20/16</u> <u>(MD) / D.O.</u>

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