

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	03	30	2016
	Month	Day	Year
2. Name of medical practice or facility at Areterm	which RU-486 was provid	ded:	
3. Address of medical practice or facility a			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Incomplete abortion	Adverse reaction to RU-486	Patient hospitalize	id
Patient received a transfusion Severe bl	eeding		
Other serious event (specify)		· · · · · · · · · · · · · · · · · · ·	
6. Duration of event:3Hours _	Days		
7. Remarks: Abortion complete	d Sorgically.	·	
8. a. Name of physician who provided RU	A86 / Mitchell	Reider,	1.0.
8. b. Physician's signature	MUL) D O
Send completed forms to: State	Medical Board of Ohio		
Legal Depart	ment		:
30 E. Broad S	St., 3 rd Floor	MEDICAL	ROARD
Columbus, O	H 43215-6127	WILLIAM	/ 1.0 (// N.1 N.1)
		MAY	2 2016

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	ed:	04	29	16
		Month	Day	Year
2. Name of medical practic	e or facility at which RU-4			
3. Address of medical pract	ice or facility at which RU	-486 was provided:		
12000 Shake	- Blud. Cl	eveland	44120	4.1.
4. Date post RU-486 compli	cation began:			
5. Event(s) (Please check all		•		
Incomplete abortion	Adverse reacti	on to RU-486 Pa	tient hospitalized	•
Patient received a transfusio	n Severe bleeding			
Other serious event (specify)		•		
6. Duration of event:	· · · · Da	ays unknou)n	
7. Remarks: Abortion compl	ided surgically	Martiere.	•	•
8. a. Name of physician who	provided RI-486 a	Mitchell 18	Poider M.T) _
8. b. Physician's signature	Date —	cell(p	MDDO	
Send completed forms to:	State Medical Bo	oard of Ohio		
	Legal Department			<i>:</i>
	30 E. Broad St., 3 rd Floor			
	Columbus, OH 43215-6	127 M I	EDICAL BOAR	

MEDICAL BOAKI

JUN 6 2016



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provi	ded:	06	17	16
2. Name of medical practi	ice or facility at which	Month RU-486 was prov	Day vided:	Year
Preterm				
3. Address of medical prac				
4. Date post RU-486 comp	lication began: $oldsymbol{\ell}$	07/05/16		
5. Event(s) (Please check a	The state of the s			
Incomplete abortion	Adverse	reaction to RU-486	Patient hospitalize	e d
Patient received a transfusion	on Severe bleeding			
			•	•
Other serious event (specify	/)		•	
6. Duration of event:	2 Hours	Days		
7. Remarks:	loted song: well	.		
8. a. Name of physician wh	o provided RU-486	V Mily	Il Rider	M.D.
8. b. Physician's signature	Da	7	7 4) _{D.O.}
Send completed forms to:		cal Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd	Floor		
	Columbus, OH 432		MEDICAL F	BOARD
	,		JUL 12	2016



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	07	30	16
	Month	Day	Year
2. Name of medical practice or facilit Arctorm	y at which RU-486 was p	provided:	
3. Address of medical practice or facil			
4. Date post RU-486 complication beg			
5. Event(s) (Please check/all that apply):		
Incomplete abortion	Adverse reaction to RU-4	Patient hospitalize	:d
Patient received a transfusion Sever	re bleeding		
Other serious event (specify)			·
6. Duration of event: Hou	rs Days		
7. Remarks:			
8. a. Name of physician who provided 8. b. Physician's signature		Hebell Reider	M.D. D.O.
	ate Medical Board of Ol	nio	
Legal Dep			
30 E. Bro	ad St., 3 rd Floor		

Columbus, OH 43215-6127

MEDICAL BOARD

SEP 6 2016