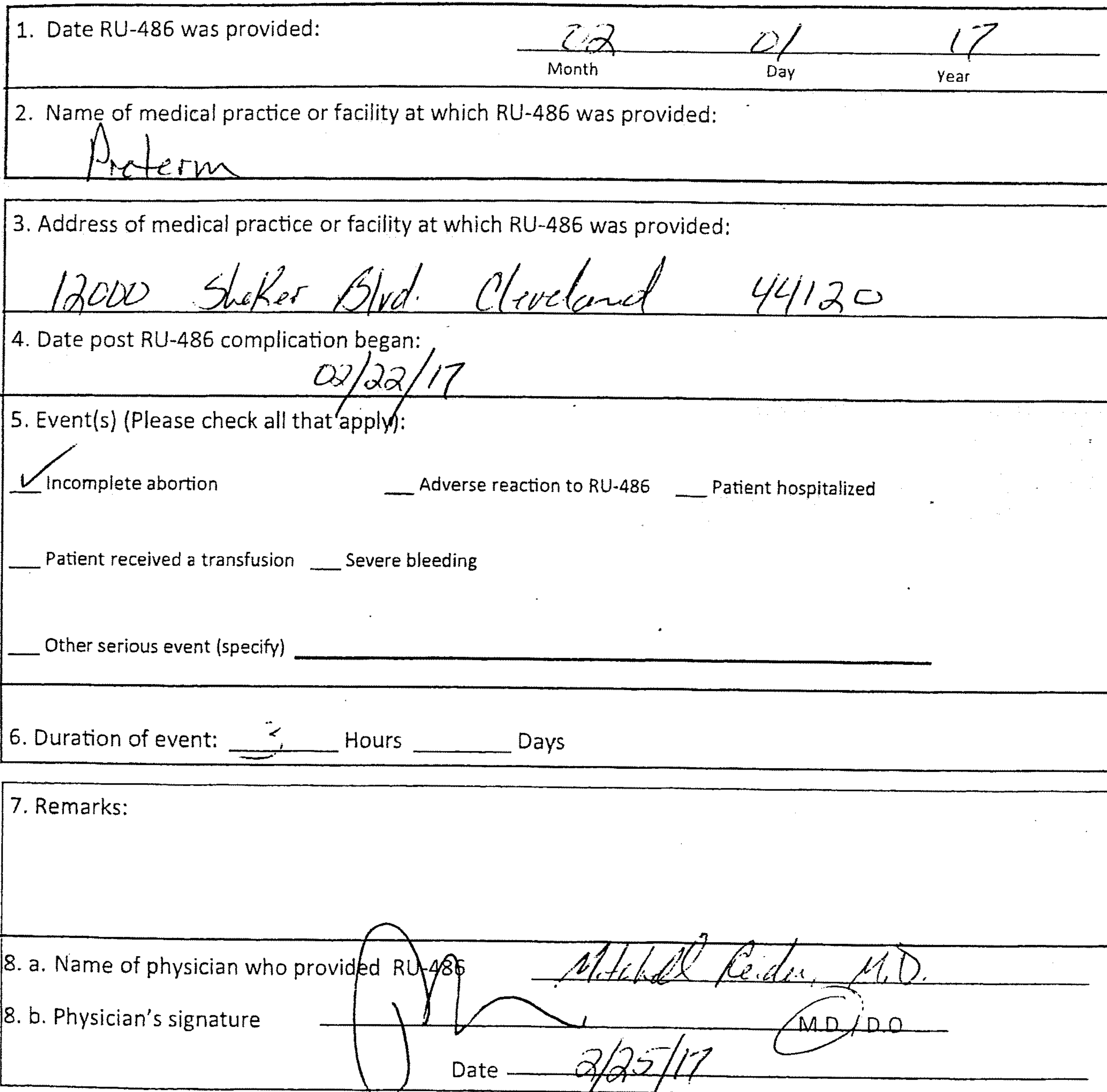
State Medical Board of Ohio

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: 02 / 01 / 17
   Month Day Year

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

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:
   02/22/17

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: 2 Hours ______ Days

7. Remarks:

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

8. b. Physician's signature ______ M.D./D.O

Date 2/25/17

Send completed forms to: State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

MAR 01 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: 02 (Month) 24 (Day) 17 (Year)

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

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:
3/10/17

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: 2 Hours ________ Days

7. Remarks:

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

8. b. Physician's signature [signature] M.D./D.O.

Date 3/11/17

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

MEDICAL BOARD
MAR 1 5 2017

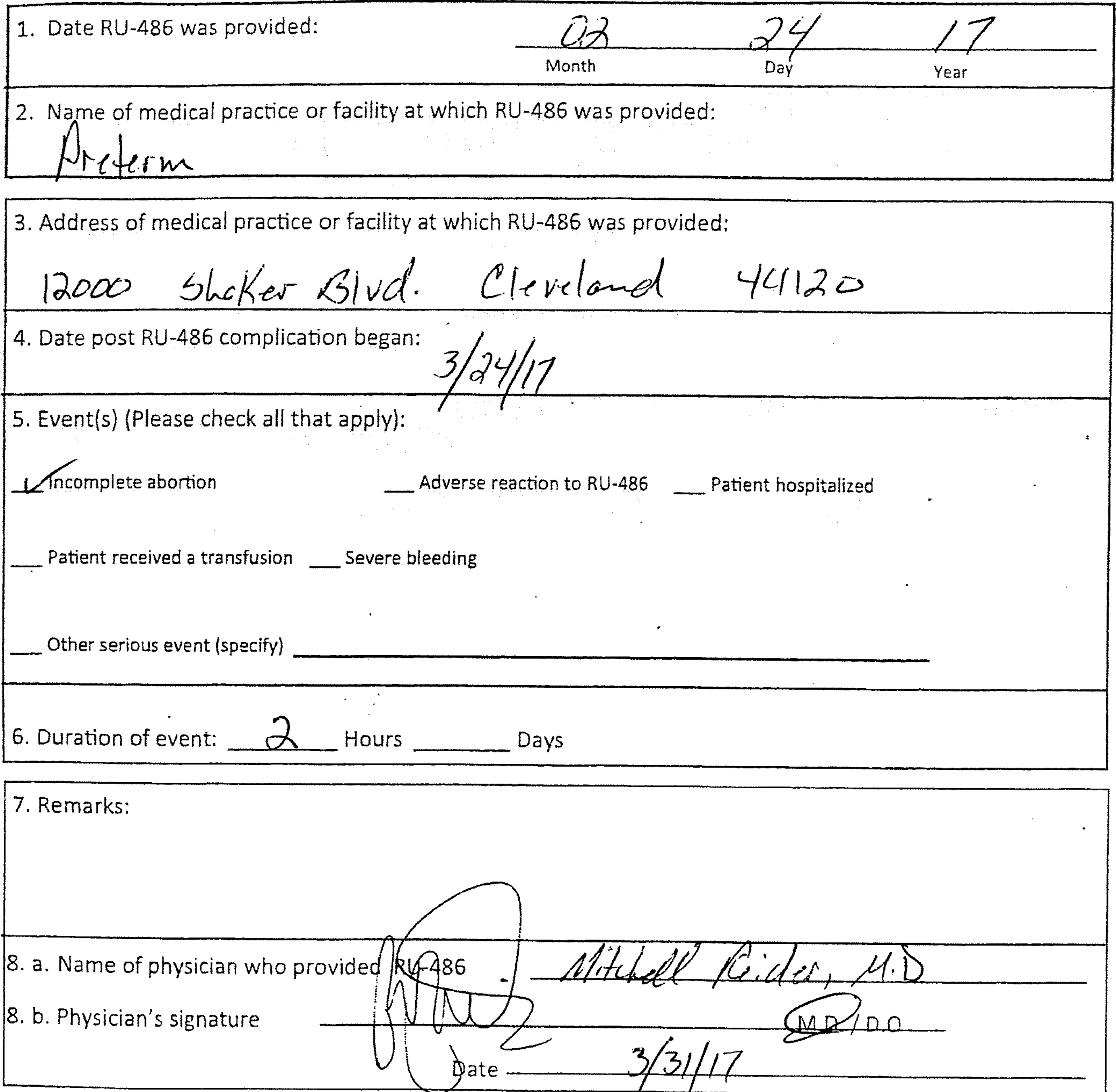
Prescribed: 5/--/2011. Rev. 12/13/12

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: 03 (Month) 24 (Day) 17 (Year)

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

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: 3/24/17

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: 2 Hours ________ Days

7. Remarks:

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

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

Date 3/31/17

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

MEDICAL BOARD

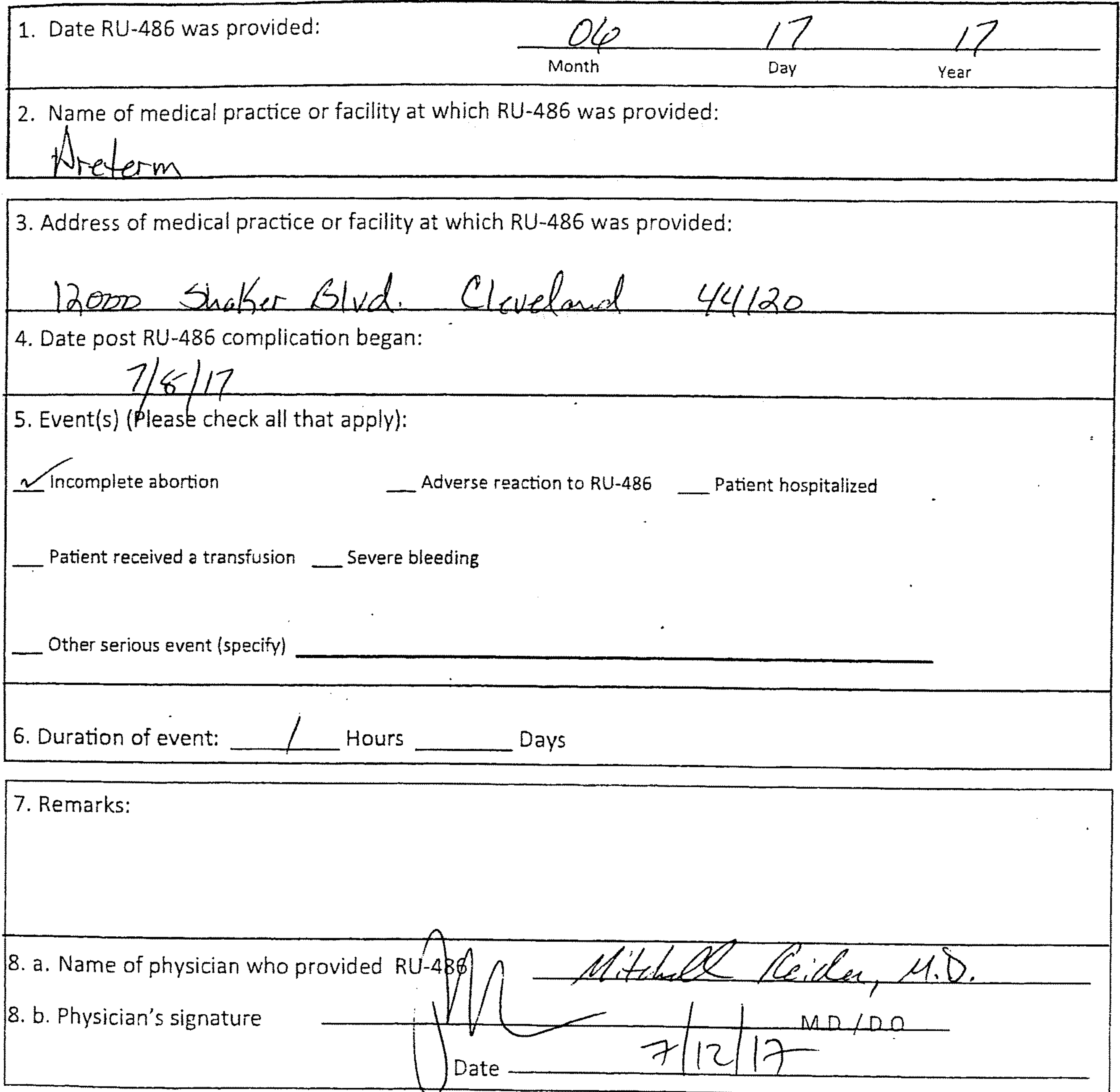
APR 03 2017

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

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: 06 (Month) 17 (Day) 17 (Year)

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

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:
7/8/17

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: 1 Hours ________ Days

7. Remarks:

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

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

Date 7/12/17

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

MEDICAL BOARD
JUL 17 2017

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

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: 07 (Month) 07 (Day) 17 (Year)

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

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: 07/21/17

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: 1 Hours ________ Days

7. Remarks:

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

8. b. Physician's signature [signature] M.D./D.O

Date 8/7/17

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

MEDICAL BOARD
AUG 07 2017

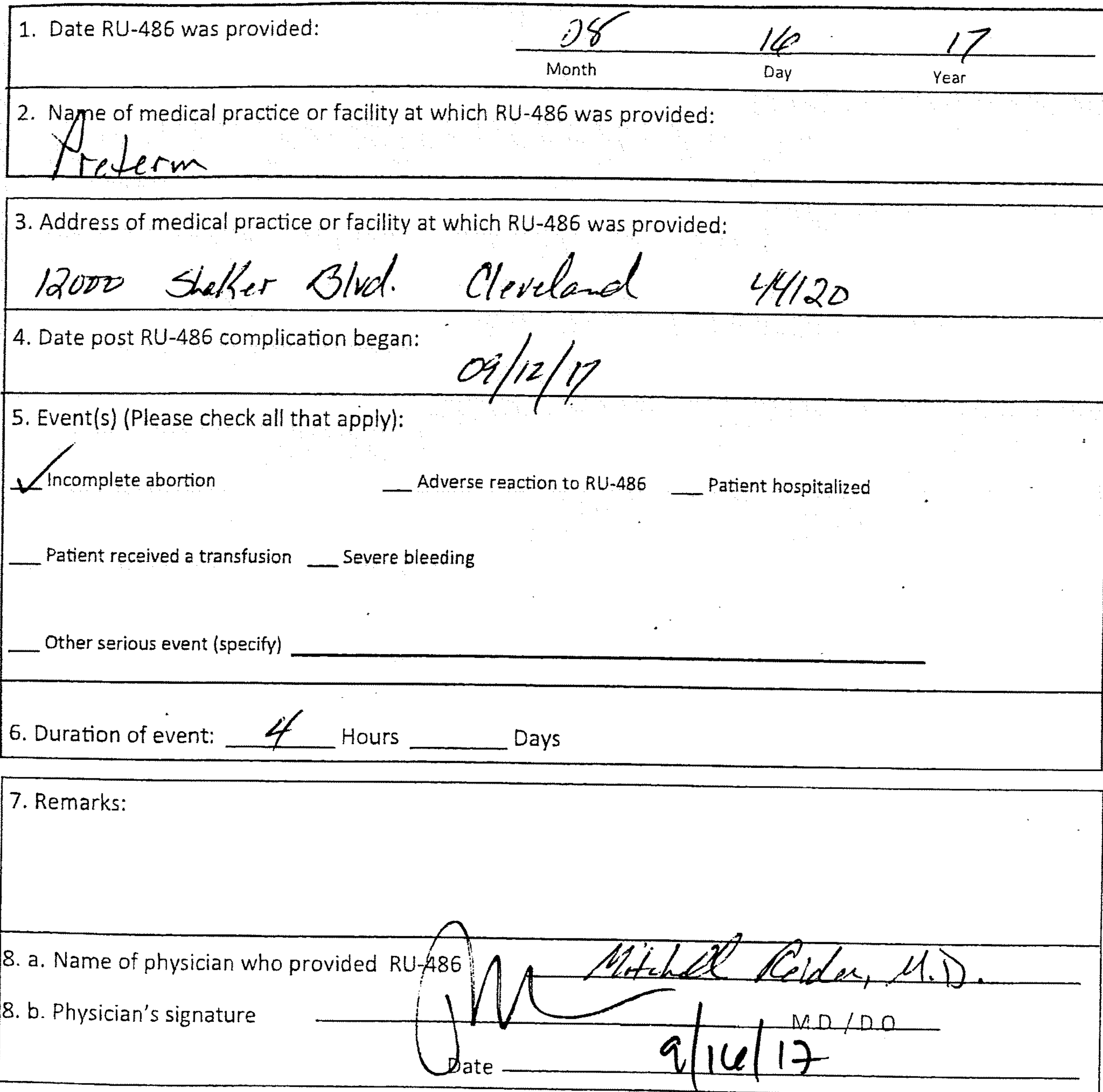
Prescribed: 5/--/2011. Rev. 12/13/12

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: 08 (Month) 16 (Day) 17 (Year)

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

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: 09/12/17

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: 4 Hours ________ Days

7. Remarks:

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

8. b. Physician's signature ________________ MD/DO

Date 9/16/17

Send completed forms to: State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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

MEDICAL BOARD

SEP 20 2017

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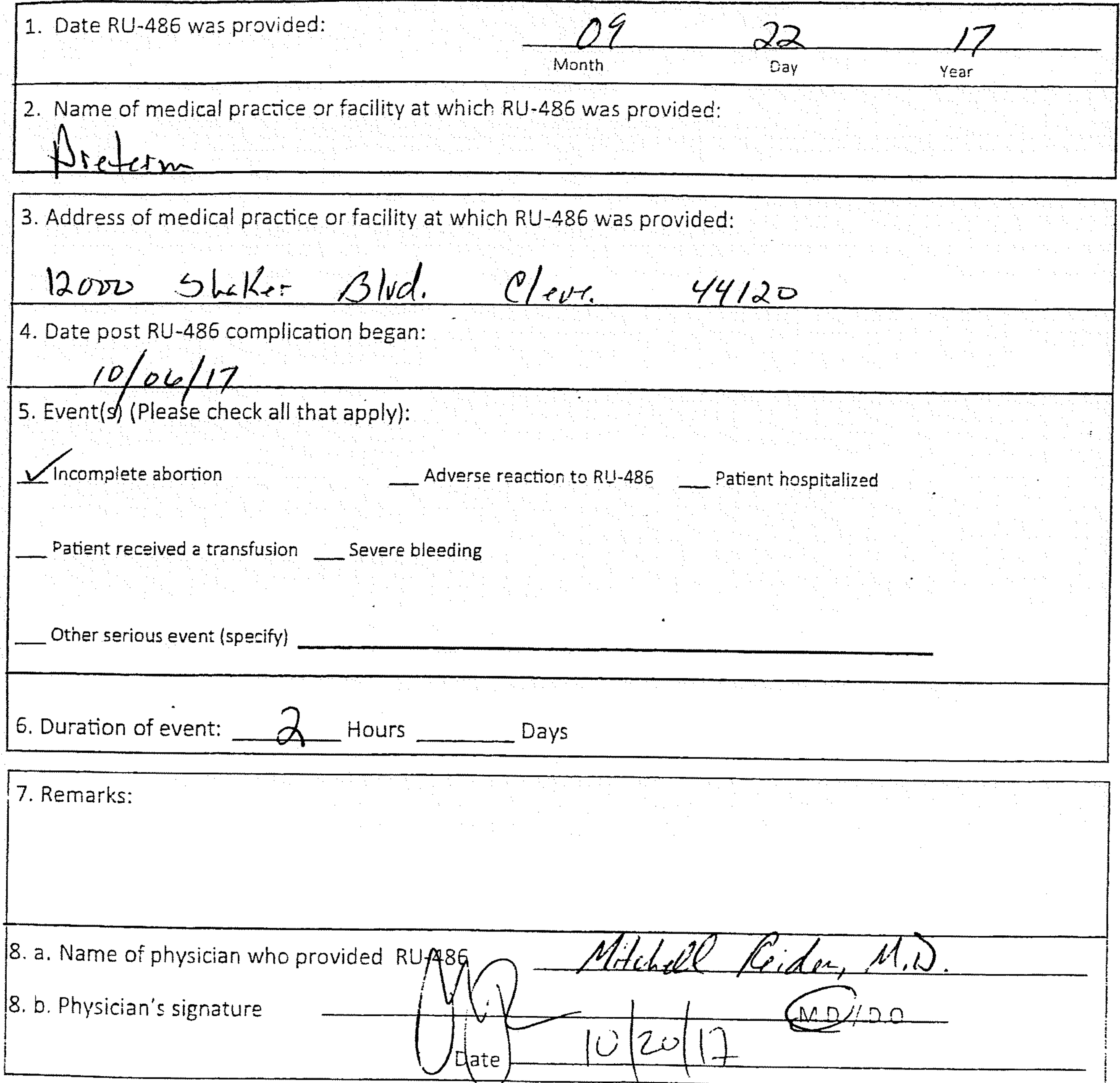
State Medical Board of Ohio

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: 09 (Month) 22 (Day) 17 (Year)

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

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

4. Date post RU-486 complication began:
10/06/17

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: 2 Hours ________ Days

7. Remarks:

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

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

Date 10/20/17

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

MEDICAL BOARD
OCT 24 2017

Prescribed: 5-- 2011 Rev. 12/13/11

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: 10 (Month) 27 (Day) 2017 (Year)

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

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

4. Date post RU-486 complication began:
11/29/17

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

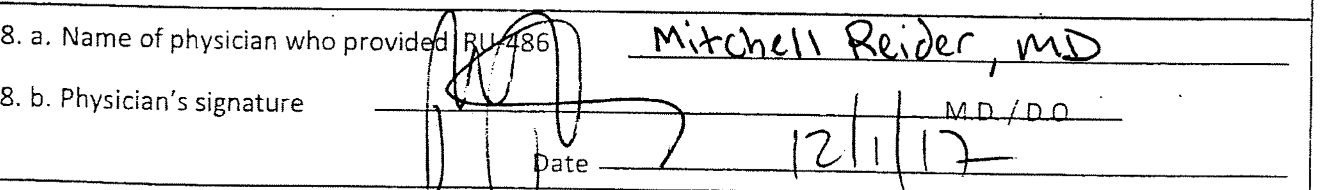
✓ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) ____________

6. Duration of event: 3 Hours ______ Days

7. Remarks:



8. a. Name of physician who provided RU-486 Mitchell Reider, MD

8. b. Physician's signature ______ M.D./D.O.

Date 12/1/17

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

DEC 06 2017

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