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 provide	ed:	03	ID.	15
		Month	Day	Year
2. Name of medical practice of the second section of the second section of the second	e or facility at which RU	J-486 was provi	ded:	
3. Address of medical practi	ce or facility at which R	U-486 was prov	vided:	
12000 Shake	er Blud.	Clevela	nd i	14120
4. Date post RU-486 complic	cation began: $O4/$	03/15		
5. Event(s) (Please check all		/		
Incomplete abortion	Adverse rea	ction to RU-486	Patient hospital	ized
Patient received a transfusion	Severe bleeding			
Other serious event (specify)				
6. Duration of event:3	Hours	Days		
7. Remarks:	completed sur	jully.		
8. a. Name of physician who	provided RU-486	Moha	mmad Re	zall
8. b. Physician's signature	MM	lysie	rey MD)0.0
	Date -	4/14/	15	
Send completed forms to:	State Medical	Board of Ohio		
•	Legal Department			
	30 E. Broad St., 3 rd Flo	or	MEDICAL	BOARD
	Columbus, OH 43215	-6127	APR 2 (2015



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 provid	led:	_05	06	2015
		Month	Day	Year
2. Name of medical praction	ce or facility at which	n RU-486 was provi	ded:	
3. Address of medical pract	ice or facility at which	ch RU-486 was pro	vided:	
12000 Shake	The North Age of the Control of the	医内部 网络拉克亚克 医克克氏		
4. Date post RU-486 compl	ication began: 6/2/15			
5. Event(s) (Please check al	l that apply):			
Incomplete abortion	Adverse	e reaction to RU-486	Patient hospitalized	
Patient received a transfusio	sa Cours blooding			
Patient received a transitisio	ii Severe bleeding			
Other serious event (specify				
6. Duration of event:	2Hours	Days		
7. Remarks:	completed :	surfically.		Proceedings of the Annual Conference on the Conference of the Conference on the Conf
	,	σ 0		
8. a. Name of physician who	provided RU-486	Moha	mucel Para	ce 4.0.
8. b. Physician's signature	ANN/ Da	te "\$ 6	12/15 (10)	D.O
Send completed forms to:	State Medi	cal Board of Ohio		
	Legal Department	,		<i>:</i>
	30 E. Broad St., 3 rd			
			MEDIC	CAL BOARD
	Columbus, OH 432	TT3-017/		
			JUI	V 5 2015

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	16	15
		Month	Day	Year
2. Name of medical practice or	facility at wh	ich RU-486 was provi	ded:	
3. Address of medical practice of	or facility at w	hich RU-486 was prov	vided:	
12000 Shaker	Blvd.	Cleveland	44120	
4. Date post RU-486 complication	on began:	15	•	•
5. Event(s) (Please check all tha				
Incomplete abortion	Adve	rse reaction to RU-486	Patient hospitalized	
Patient received a transfusion	_ Severe bleedi	ng		
Other serious event (specify)	•	•		
6. Duration of event: 2.5	Hours	Days .		
7. Remarks:				•
Abortion con	mptotad	sugically.		
8. a. Name of physician who pro	vided RU-486	Mohan	unad Roza	ee
8. b. Physician's signature	MM)	Sur 1/1	4/15	0.0
Send completed forms to:	State Me	dical Board of Ohio		
Le _l	gal Departme	nt		:
30	E. Broad St., 3	3 rd Floor		
Сσ	lumbus, OH 4	3215-6127	MEDICAL	BOARD

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

JUL 2 0 2015