

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

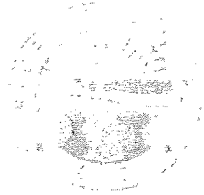
1. Date RU-486 was provided:	<u>03</u>	<u>10</u>	<u>15</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Preterm</u>		
3. Address of medical practice or facility at which RU-486 was provided:	<u>12000 Shaker Blvd. Cleveland 44120</u>		
4. Date post RU-486 complication began:	<u>04/03/15</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>Mohammad Rezaei</u>		
8. b. Physician's signature	<u>Mohammad Rezaei MD/DO</u>		
	Date	<u>4/14/15</u>	

Send completed forms to: State Medical Board of Ohio

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

MEDICAL BOARD

APR 20 2015



State Medical Board of Ohio Report of RU-486 Event

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To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>05</u> Month	<u>06</u> Day	<u>2015</u> 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>6/2/15</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>Mohammed Razaee, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> <u>M.D. D.O.</u>			
Date <u>6/2/15</u>			

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MEDICAL BOARD

JUN 5 2015



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1. Date RU-486 was provided: 06 / 16 / 15
Month Day Year

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

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

4. Date post RU-486 complication began:
7/10/15

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: 2.5 Hours _____ Days

7. Remarks:
Abortion completed surgically.

8. a. Name of physician who provided RU-486 Mohammad Rezaee

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

Date 7/14/15

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MEDICAL BOARD
 JUL 20 2015

