

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	23	2016			
	Month	Day	Year			
2. Name of medical practice or facility at which RU-486 was provided:						
Protorn						
3. Address of medical practice or facility at which RU-486 was provided:						
12000 Shaker Blvd. (4. Date post RU-486 complication began:	Cleveland	44120				
4. Date post RU-486 complication began:						
03/26	116	CATTAGE LYST	T.			
5. Event(s) (Please check all that apply):						
	reaction to RII-486	Patient hospitalized				
Adverse	reaction to No-400	r attent nospitalized				
Patient received a transfusion Severe bleeding						
			•			
Other serious event (specify)						
6 Duration of sucety 7	Dove					
6. Duration of event: Hours Days						
7. Remarks:						
Abortion completed surgically.						
	1					
	· · · · · · · · · · · · · · · · · · ·					
8. a. Name of physician who provided RU-486	Mohan	mad Rozace				
8. b. Physician's signature	Vagua	(MD)	0			
	ote	4616				
		,				
Send completed forms to: State Medical Board of Ohio						

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

APR 1 1 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:	02	24	16
	Month	Day	Year
2. Name of medical practice or facility at a	which RU-486 was prov	ided:	
3. Address of medical practice or facility at	t which RU-486 was pro	vided:	
12000 Shaker Blud.	Cleveland	44120	en e
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			**************************************
Incomplete abortion A	dverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe ble	eding		
Other serious event (specify)	•		
6. Duration of event: 2 Hours	Days		
7. Remarks: Abortion completed	surgially.		· .
8. a. Name of physician who provided RU-	486 Moha	mmad Rezaes	2
8. b. Physician's signature	Date 46	1 MDD	0
Send completed forms to: State	Medical Board of Ohio		
Legal Departr	ment		<i>‡</i>
30 E. Broad S	t., 3 rd Floor	MEDICAL B	OARD
Columbus, Ot	H 43215-6127		
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Prescribed: 5/--/2011, Rev. 12/13/12

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provid	ed:	07	06	16
		Month	Day	Year
2. Name of medical practic	e or facility at wh	nich RU-486 was p	rovided:	
3. Address of medical practi	ce or facility at w	hich RU-486 was	provided:	
12000 Shaker	Blvd. C	leveland	44120	
4. Date post RU-486 compli <i>OB</i>	cation began:			
5. Event(s) (Please check all	that apply):			
Incomplete abortion Patient received a transfusion			86 Patient hospitaliz	ed
Other serious event (specify)	•	•	•	
6. Duration of event:	Hours	Days		
7. Remarks:	The state of the s			, ,
			•	
8. a. Name of physician who	provided RU-48	66 Mo	Lammad Rezace	, M.D.
8. b. Physician's signature	-M	Date	31/6 MD	P.O
Send completed forms to:	State Me	edical Board of Oh	nio	
	Legal Departme	ent ,		• • •
	30 E. Broad St.,	3 rd Floor		
	Columbus, OH	43215-612 7		

Prescribed: 5/--/2041, Rev. 12/13/12

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