(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		02	13	2018
		Month	Day	Year
2. Name of medical practice or f	acility at which R	U-486 was provid	led:	
Preterm				
	-			
3. Address of medical practice or				
12000 Shaker F	31vd. C1	ieveland,	CH 441	20
4. Date post RU-486 complication 31018	n began:	•		
5. Event(s) (Please check all that	apply):	•		
Incomplete abortion	Adverse re	action to RU-486	Patient hospitaliz	ed
Patient received a transfusion	Severe bleeding			•
Other serious event (specify)				······································
6. Duration of event:	Hours	Days		
7. Remarks:		<u> </u>		
•				
3. a. Name of physician who provi	ded RU-486	Monique	2 Katsuki	am.
3. b. Physician's signature	MiloCo	A .	MD /	/ :n o
	O _{Date -}	3/20/18		
end completed forms to:	State Medical I	Board of Ohio		
Legal	Department			
30 E.	Broad St., 3 rd Floo	or		
Colur	mbus, OH 43215-	6127		man de la managa de la companya de l

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

MAR : 3 2018

MEDICAL BOARD

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provid	ded:	05	15	2018
		Month	Day	Year
. Name of medical practic	ce or facility at which	RU-486 was provide	ied:	
Preterm				
Addrson of an alicely and	hoo or facility -t -t-	h DII 196	idad.	
3. Address of medical pract	use or racility at whic	n nu-400 was prov	noed:	
12000 Shaker	Blvd. Clev	cland. OH	44120	
4. Date post RU-486 compl	The state of the s			gregorialista progressi discontrata contrata progressi anticontrata contrata della contrata di contrata di con Contrata di Contrata di Co Contrata di Contrata di Co
6/5/18	en e			
5. Event(s) (Please check al	I that apply):			
		% <u>=</u>		
Incomplete abortion	Adverse	reaction to RU-486	Patient hospitali	zed
Patient received a transfusion	n Severe bleeding			
com received a management	o=v=re piesuing			
Other serious susat In-				
Other serious event (specify	1			
	3			
6. Duration of event:	O Hours	Days		
7. Remarks:				
•				
	V-1			
3. a. Name of physician who	o provided RU-486	Monique	L Katsuki	, mD
3. b. Physician's signature	***************************************	mydil	Pat	/ <u>n</u> .o
,	Dat	10/10	2/18	-
end completed forms to:		cal Board of Ohio		
	Lega! Department			
	30 E. Broad St 3"	Floor		-
	Columbus, OH 432	15-6127		MEDICAL BOARI
				MILL

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provi	ded:	05	29	2018	
		Month	Day	Year	
2. Name of medical pract	ice or facility at which RI	J-486 was provid	ded:		
Preterm					
3. Address of medical prac	tice or facility at which I	RU-486 was prov	vided:		
12000 Shaker	Blud Cleve	land, OH	44120		
4. Date post RU-486 comp	lication began:				
5. Event(s) (Please check a	ll that apply):				
✓Incomplete abortion	Adverse re	action to RU-486	Patient hospitalize	d	
Patient received a transfusi	on Severe bleeding				
				•	
Other serious event (specify	v)				
6. Duration of event:	Hours Q	Days			
7. Remarks:					·
3. a. Name of physician wh	o provided RU-486	Mariane	, KatsuKi	MI	one
• •	1211				
3. b. Physician's signature	Date -	(1/18/18	(MD/	D.O.	
end completed forms to:	State Medical	Board of Ohio			
	Legal Department				
	30 E. Broad St., 3 rd Flo	or	MEDICAL BO	OARD	
/	Columbus, OH 43215	-6127	JUN 2 6 2	018	
/			υψι υ ψ 'λ	• . •	
rescribed: 5/2011. Rev. 12/13/12					

(Required pursuant to P.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	_08	14	2018
	Month	Say	Year
2. Name of medical practice or facility a Preferm	et which RU-486 was prov	ided:	
B. Address of medical practice or facility	at which RU-486 was pro	vided:	
12000 Shaker Blvd.	Cleveland, o	H 4412	0
1. Date post RU-486 complication began			
. Event(s) (Please check all that apply):			
Incomplete abortion	Adverse reaction to RU-486	Patient hospitali	zed
Patient received a transfusion Severe bi	leeding		
Other serious event (specify)			
Duration of event: Hours _	Days		
Remarks:			
a. Name of physician who provided RU-	486 Mani 9	ie Kritsuk	Cimo
b. Physician's signature	nycant	- M.D./	
	Date 9/4/18		
nd completed forms to: State	Medical Board of Ohio		
Lega! Departr	nent		
30 E. Broad St	3°° Floor		•
20 E. 5108C 3(, 2 1130:		

Prescriped: 5 - 2022, Rev. 12/13/12

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