

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>01</u>	<u>26</u>	<u>2018</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, OH 44120</u>			
4. Date post RU-486 complication began:			
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:			
8. a. Name of physician who provided RU-486: <u>Mitch Reider, MD</u>			
8. b. Physician's signature: _____ Date: <u>2/21/18</u> MD/DO			

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

FEB 28 2018

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>01</u>	<u>05</u>	<u>2018</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Pre-term</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleveland, OH 44120</u>			
4. Date post RU-486 complication began: <u>1/27/18</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:			
8. a. Name of physician who provided RU-486 <u>Mitch Reider, MD</u>			
8. b. Physician's signature _____ M.D./D.O. _____ Date <u>2.9.18</u>			

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127


MEDICAL BOARD

FEB 15 2018

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>02</u>	<u>13</u>	<u>2018</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, OH 44120</u>			
4. Date post RU-486 complication began: <u>3/10/18</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: 			
8. a. Name of physician who provided RU-486 <u>Monique Katsuki, MD</u>			
8. b. Physician's signature <u></u> MD/DO _____ Date <u>3/20/18</u>			

Send completed forms to: State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

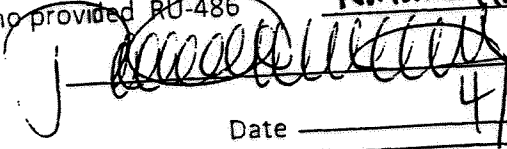
MEDICAL BOARD

MAR 13 2018

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:	3	14	2018
	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, OH 44120			
4. Date post RU-486 complication began: 3/31/2018			
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: 3 Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486: Natalie Hinchcliffe, DO			
8. b. Physician's signature:  M.D. (D.O.)			
Date: 4/7/18			

Send completed forms to:

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

MEDICAL BOARD

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>05</u>	<u>15</u>	<u>2018</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, OH 44120</u>			
4. Date post RU-486 complication began: <u>6/5/18</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: 			
8. a. Name of physician who provided RU-486 <u>Monique Katsuki, MD</u>			
8. b. Physician's signature <u>[Signature]</u> MD/DO _____			
Date <u>6/12/18</u>			

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Columbus, OH 43215-6127

MEDICAL BOARD

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:	05	29	2018
	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, OH 44120			
4. Date post RU-486 complication began: 6/4/2018			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input checked="" type="checkbox"/> Patient hospitalized <input checked="" type="checkbox"/> Patient received a transfusion <input checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>2</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Monique Katsuki, MD</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u> Date <u>6/18/18</u>			

Send completed forms to: State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

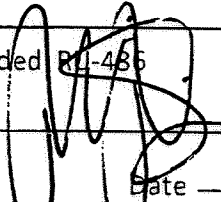
MEDICAL BOARD

JUN 26 2018

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to P.C. 2915.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	05 Month	05 Day	2018 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, OH 44100			
4. Date post RU-486 complication began: 6/23/18			
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: 4 Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486: Mitch Reider, MD			
8. b. Physician's signature:  MD / DO Date: 6/23/18			

Send completed forms to: State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

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:

04

20

2018

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, OH 44120

4. Date post RU-486 complication began:

6/30/18

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) _____

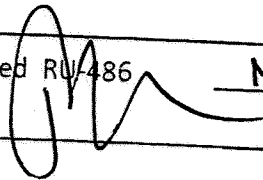
6. Duration of event: 3 Hours _____ Days

7. Remarks:

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

Mitch Reider, MD

8. b. Physician's signature



Date

7/25/18

MD/DO

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL

JUL 30

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

13

2018

Month

Day

Year

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

Preterm Cleveland

3. Address of medical practice or facility at which RU-486 was provided:

12000 Shaker Blvd Cleveland, OH 44120

4. Date post RU-486 complication began:

7/11/18

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

Mitch Reider, MD

8. b. Physician's signature

Date

7/25/18

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD OF OHIO

JUL 31

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

14

2018

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, OH 44120

4. Date post RU-486 complication began:

8/29/18

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

Monique Katsak, MD

8. b. Physician's signature



MD/DO

Date

9/4/18

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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:

8

15

2018

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, OH 44120

4. Date post RU-486 complication began:

9/5/18

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

Mitch Reider, MD

8. b. Physician's signature

MR

Date

9/12/18

MD/DO

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

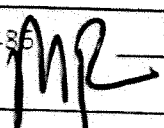
Columbus, OH 43215-6127 **MEDICAL BOARD**

SEP 17 2018

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:	8	18	2018
	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, OH 44120			
4. Date post RU-486 complication began: 9/1/18			
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: 2 Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486: Mitch Reider, MD			
8. b. Physician's signature:  (MD) DO			
Date: 9/12/18			

Send completed forms to: State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

SEP 17 2018

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: 8 15 2018
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, OH 44120

4. Date post RU-486 complication began:

9/8/18

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

MR

Mitch Reider, MD

8. b. Physician's signature

[Signature]

Date

9.21.18

(1/2) 100

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

SEP 26 2018

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:

November 10 2018

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, Oh 44120

4. Date post RU-486 complication began:

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:

6

Hours

Days

7. Remarks:

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

Mitchell Reider, MD

8. b. Physician's signature

MR

M.D. / D.O.

Date

11/23/2019

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127