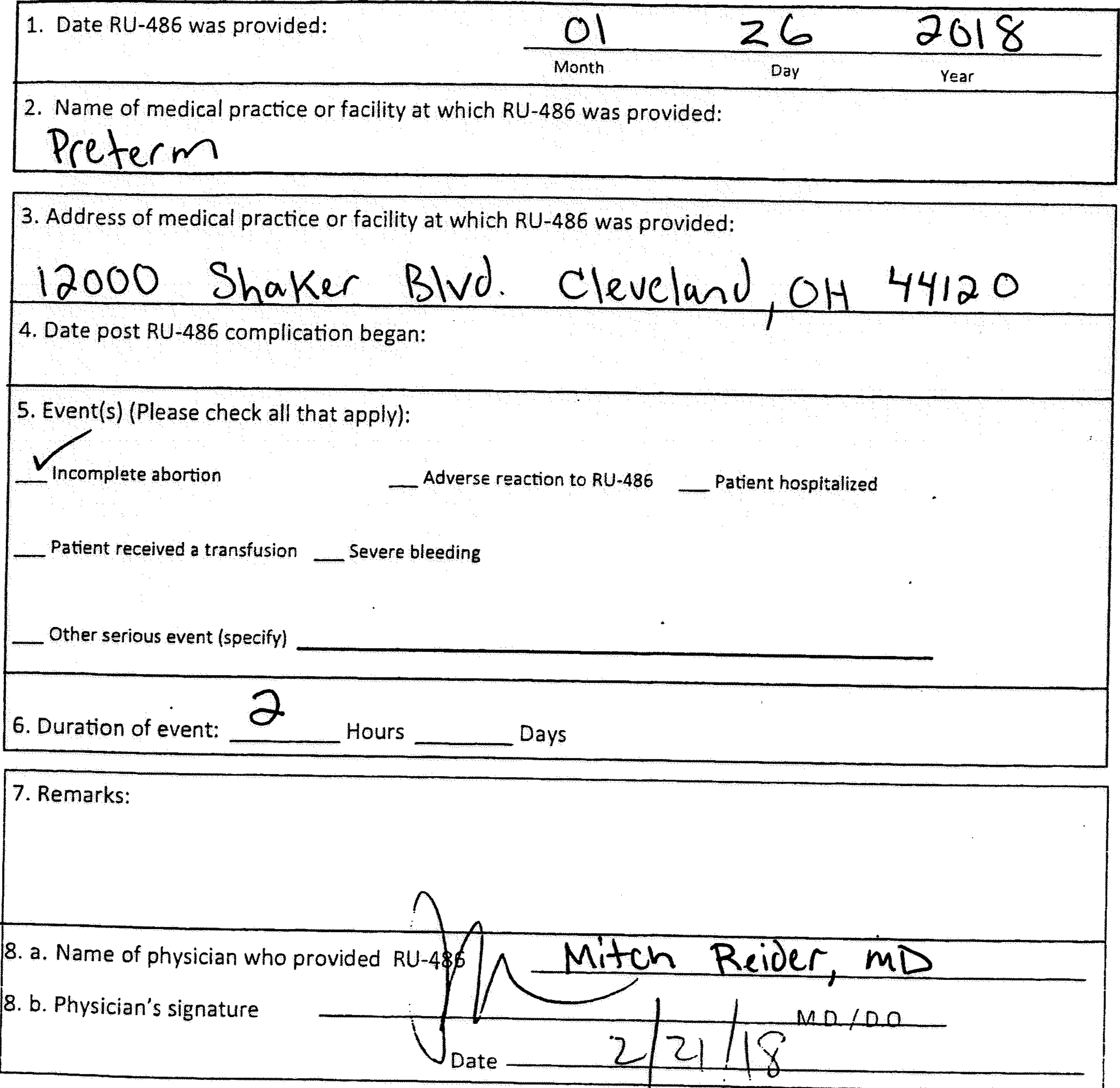
State Medical Board of Ohio

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: 01 (Month) 26 (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 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: 2 Hours ______ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Mitch Reider, MD

8. b. Physician's signature ______ M.D./D.O.

Date 2/21/18

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

MEDICAL BOARD

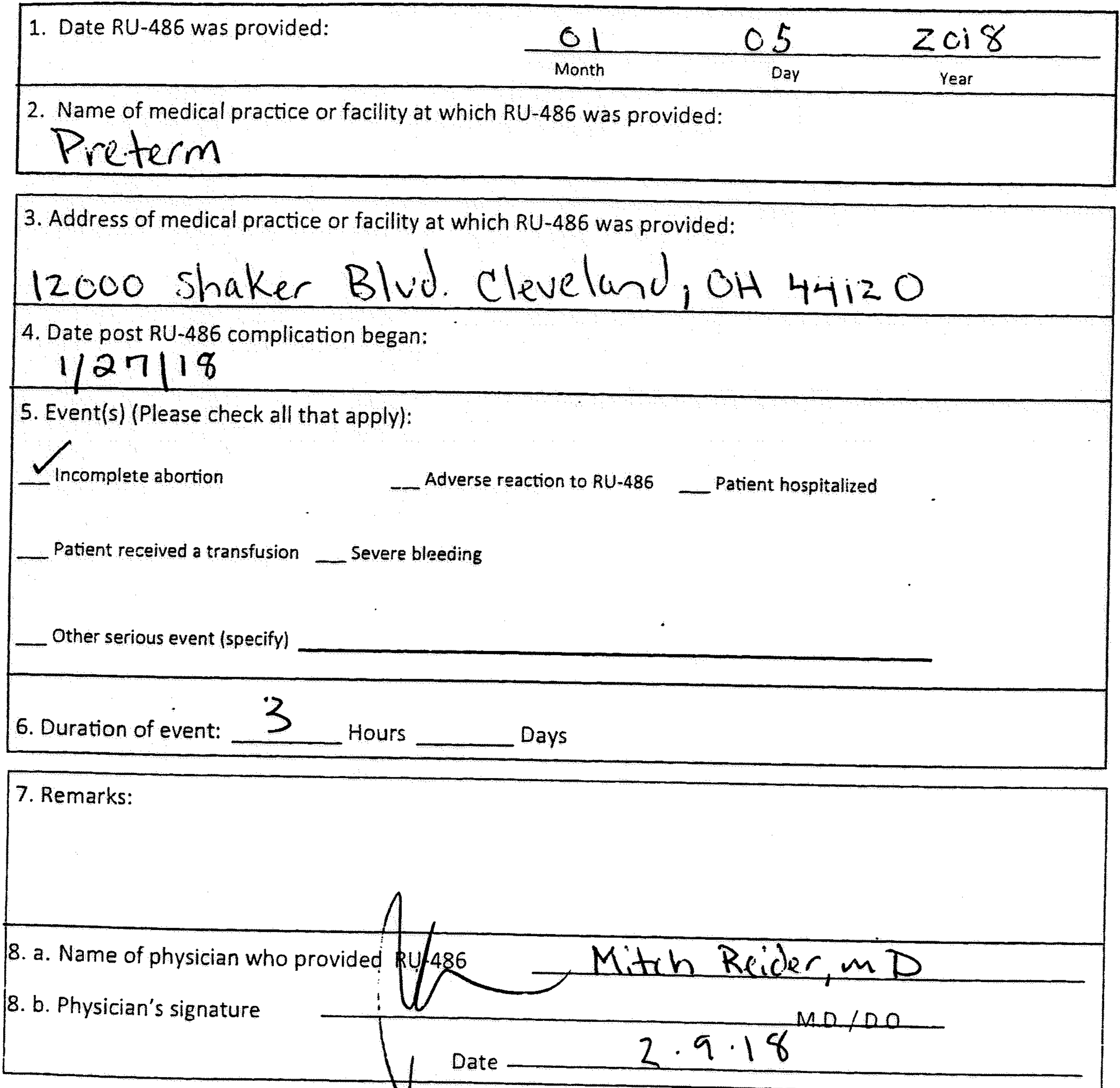
Prescribed: 5/--/2011, Rev. 12/13/12

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: 01 (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 44120

4. Date post RU-486 complication began:
1/27/18

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 ______________________ M.D./D.O.

Date 2.9.18

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

MEDICAL BOARD

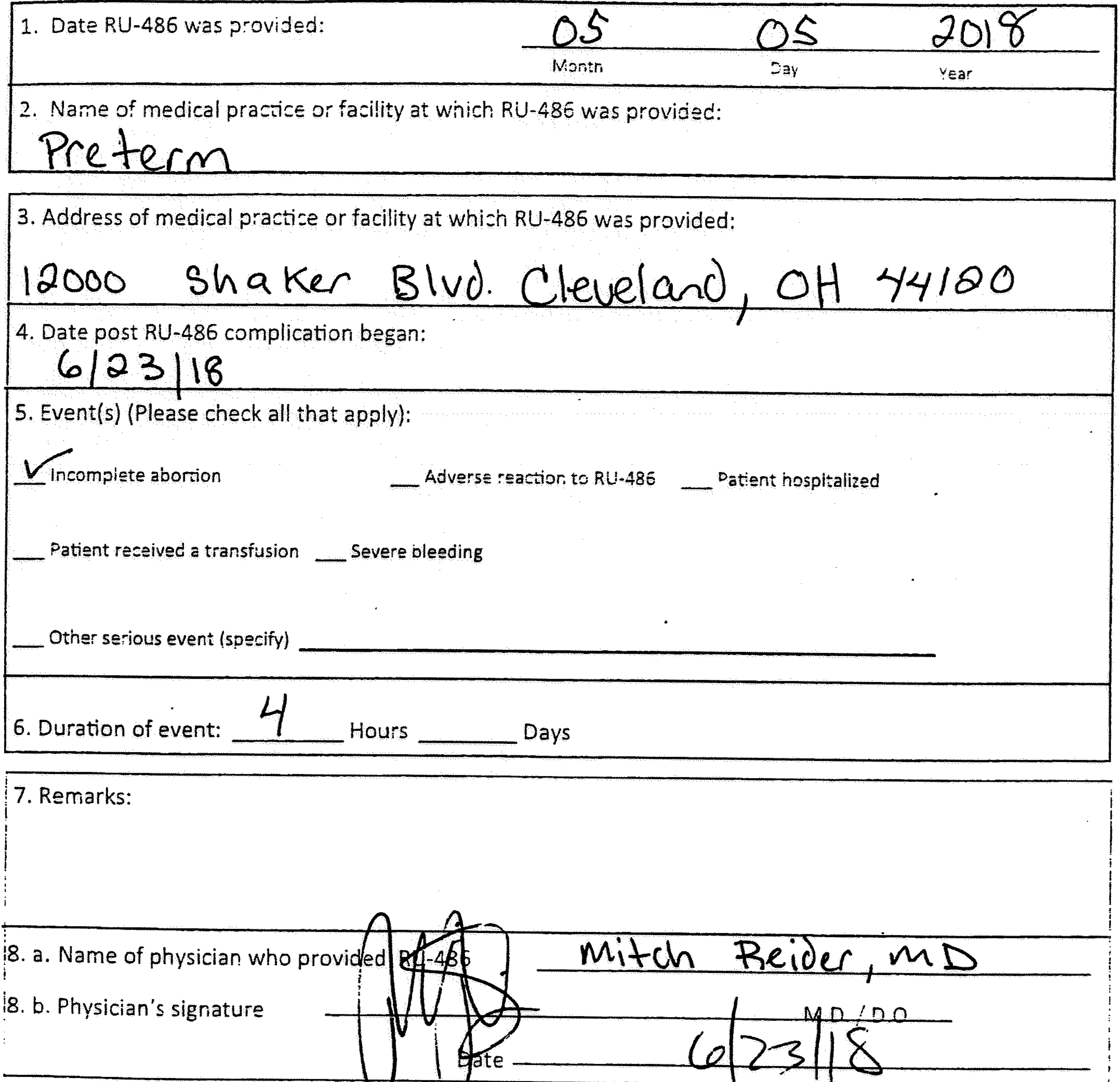
FEB 15 2018

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: 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 44120

4. Date post RU-486 complication began:
6/23/18

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 Mitch Reider, MD

8. b. Physician's signature [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

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: 04 (Month) 20 (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 44120

4. Date post RU-486 complication began:
6/30/18

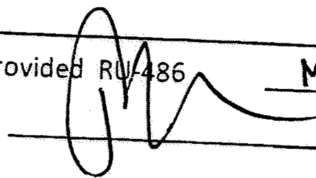
5. Event(s) (Please check all that apply):

✓ 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  M.D./D.O.

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
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 (Month) 13 (Day) 2018 (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 [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
JUL 3

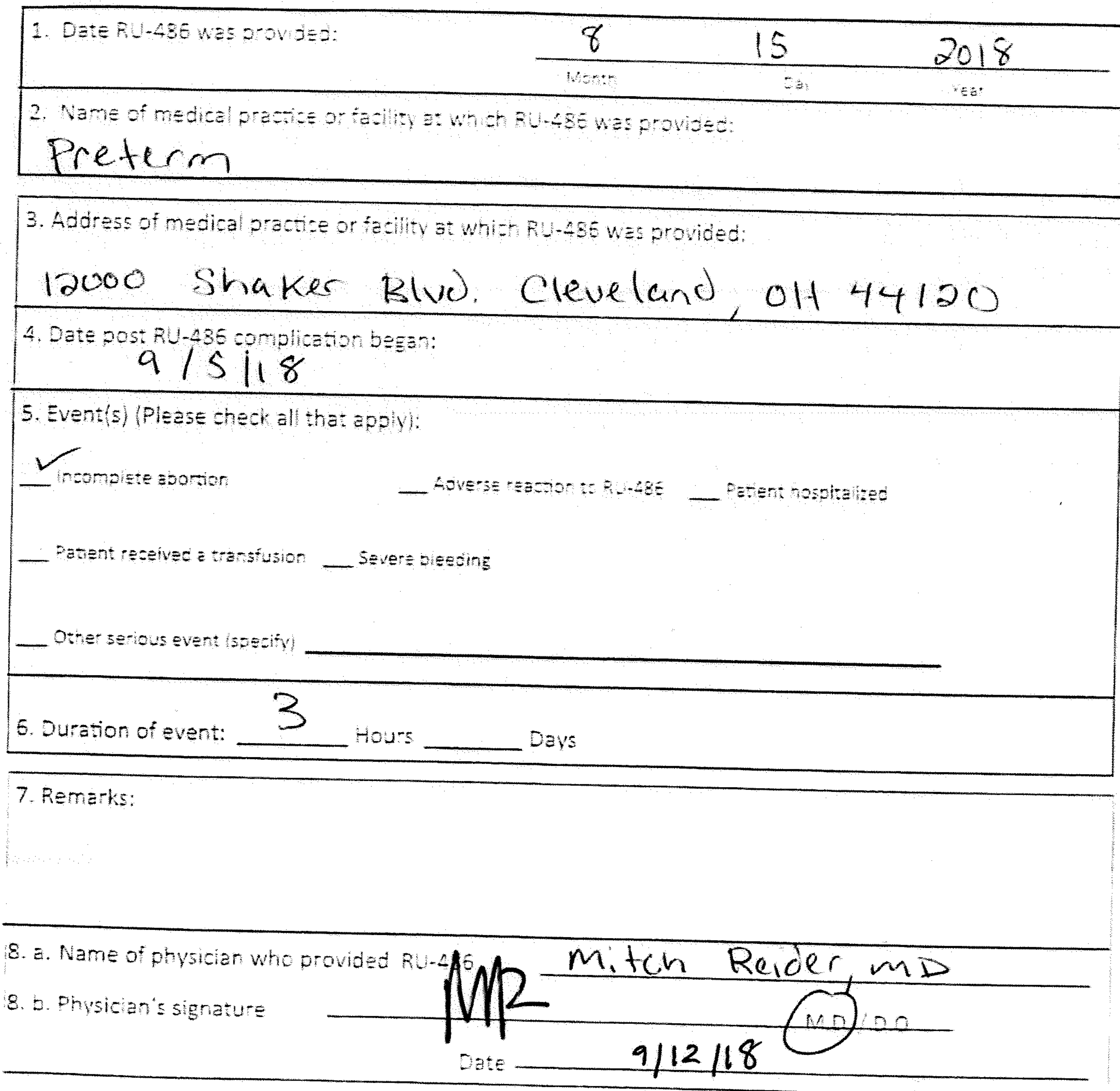
Prescribed 5 -- 2020 Rev. 10 15 10

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 (Month) 15 (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 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 [signature] M.D./D.O. (M.D. circled)

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

Prescribed [illegible]

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 (Month) 18 (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 44120

4. Date post RU-486 complication began:
9/1/18

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: 2 Hours ______ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Mitch Reider, MD

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

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 (Month) 15 (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 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 Mitch Reider, MD

8. b. Physician's signature [signature] MD / DO

Date 9·21·18

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

MEDICAL BOARD
SEP 25 2018

Prescribed 5-4-2005 Rev. 11-15-11

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):

   X 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 [signature] MD / DO

Date 1/23/2019

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

Prescribed [illegible] Rev. [illegible]