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: 2 (Month) 19 (Day) 2020 (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

4. Date post RU-486 complication began: 4/10/2020

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: 4 Hours 0 Days

7. Remarks:

8. a. Name of physician who provided RU-486: Mitchell Rader MD

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

Date: 4/29/2020

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

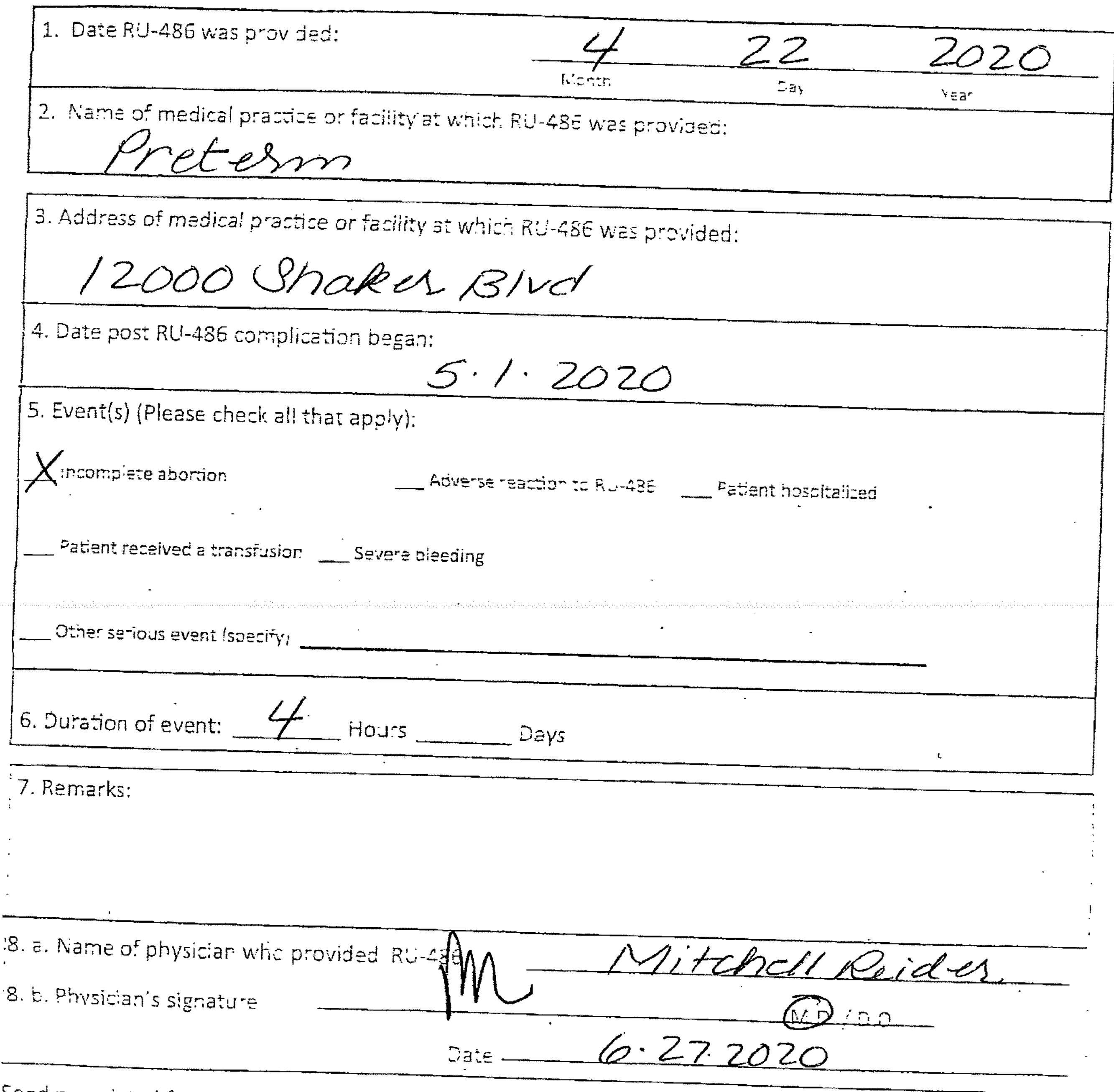
MEDICAL BOARD
JUN 05 2020

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: 4 (Month) 22 (Day) 2020 (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

4. Date post RU-486 complication began: 5 · 1 · 2020

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: 4 Hours ___ Days

7. Remarks:

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

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

Date 6 · 27 · 2020

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

MEDICAL BOARD
[illegible]

[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:	4 (Month) 22 (Day) 2020 (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:	5·9·2020

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: 4 Hours ______ Days

7. Remarks:

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

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

Date 6·27·2020

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: 4 / 29 / 2020 (Month / Day / Year)

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

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

4. Date post RU-486 complication began:
5.30.2020

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

___ incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify): Failed Abortion

6. Duration of event: 4 Hours ______ Days

7. Remarks:

8. a. Name of physician who provided RU-486: Mitchell Reider

8. b. Physician's signature MR (M.D.) D.O.

Date 6.27.2020

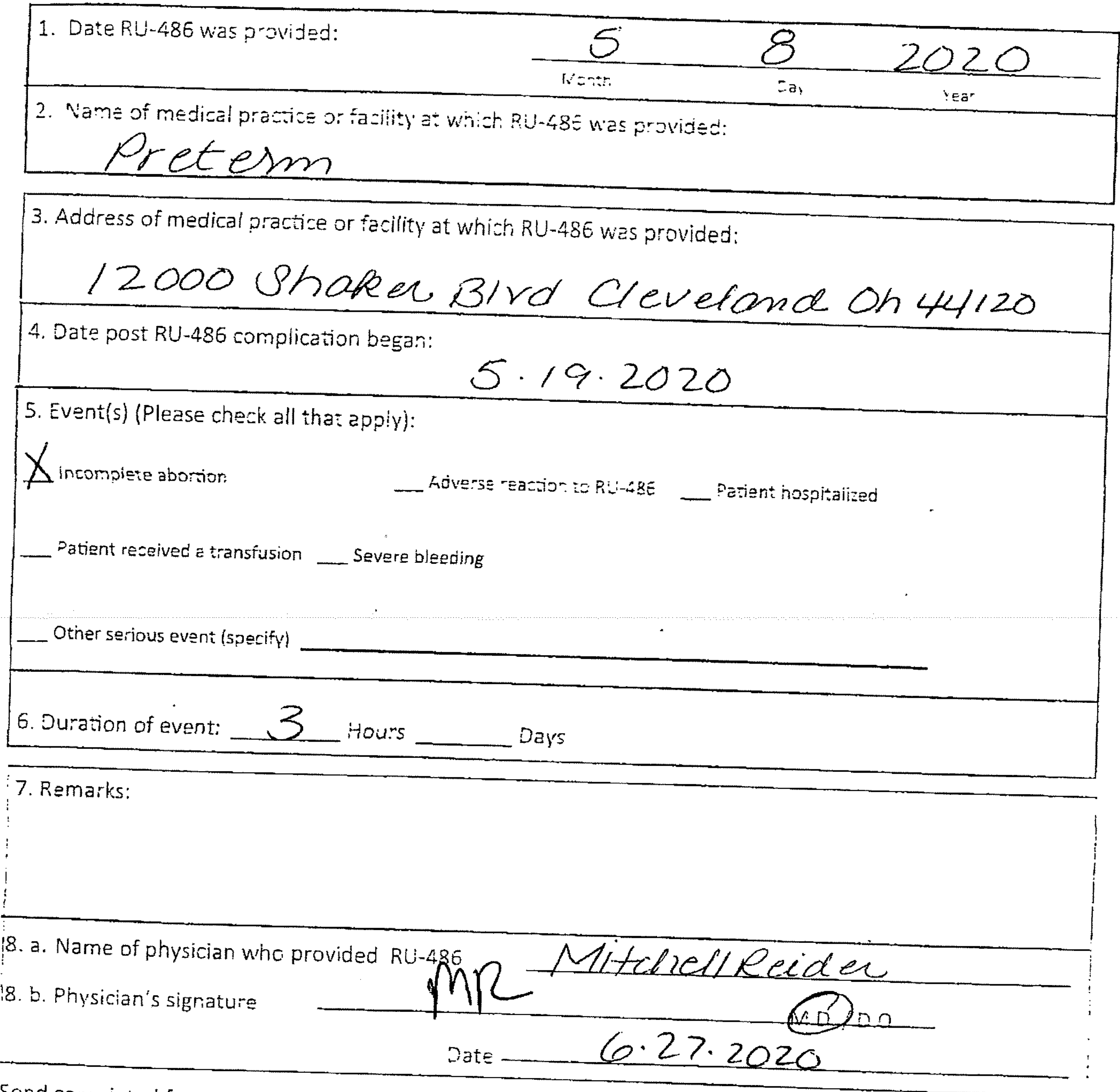
Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St. 3rd Floor
Columbus OH 43215-6127

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: 5 (Month) 8 (Day) 2020 (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: 5·19·2020

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: 3 Hours ______ Days

7. Remarks:

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

8. b. Physician's signature MR (MD) DO

Date 6·27·2020

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 -- 2021 Rev. 10/13/10

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: 06 (Month) 09 (Day) 2020 (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:
6·20·2020

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

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed Abortion

6. Duration of event: 4 Hours ___ Days

7. Remarks:

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

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

Date 6·27·2020

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

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Prescribed 5 -- 2012 Rev 10 13 10