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 Ruder MD

8. b. Physician's signature: MR 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 43215-6127

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 Reiders

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

JUL 06 2020

Prescribed 3 - 2021 Rev. 04-11-20

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.

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 (Month) 29 (Day) 2020 (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 Shaker 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: MR Mitchell Reider

8. b. Physician's signature _____ MD

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

Form RU-486, Rev. 11-01-11

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: 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 MR Mitchell Reider

8. b. Physician's 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

Prescribed 5 - 2021 Rev 10/13/11

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: 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 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

Prescribed 5 -- 2021 Rev. 12-18-12

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