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 (Month) 9 (Day) 2021 (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: 11/12/21

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 Miriam Cremer, MD

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

Date 3/8/2022

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

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