

(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:		2.6	
	Month		<u> </u>
2. Name of medical practice or facility Planned Parenthou	y at which RU-486 was pro	•	Year
3. Address of medical practice or facili	ity at which RU-486 was p	rovided:	
2314 Auburn Au			
4. Date post RU-486 complication beg	an:		
5. Event(s) (Please check all that apply):		
Incomplete abortion	Adverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe	e bleeding		
Other serious event (specify)			
6. Duration of event: 2 Hours	s Days		
7. Remarks:			
١.			
.a. Name of physician who provided F	RU-486	Pemah	
. b. Physician's signature		1\2M	10
	Date —	5/26/2	
end completed forms to: Sta	te Medical Board of Ohio		
Legal Depa		MF	DICAL BOARD
	d St., 3 rd Floor	1916	JUN 1 4 2021
Columbus,	OH 43215-6127		JOH T

MEDICAL BOARD



State Medical Board of Ohio Report of RU-486 Event

MAY 1 0 2021

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

A. D. Bilance	<u> </u>		
1. Date RU-486 was provided:	HPMI	9	<u> 202/</u>
	Month	Day	Year
Name of medical practice or facility at wh	ich RU-486 was provide	d:	a to the state of
Women's Med Dayton			
 Address of medical practice or facility at w 1401 E Stroop Rd 	hich RU-486 was provid	led:	
Dayton, Ohio 45429			
,			
4. Date post RU-486 complication began:	4-30-208	Ll	
5. Event(s) (Please check all that apply):		4	7 18/4 marketin till to
Incomplete abortionAdve		Book of the second	
AOVE	erse reaction to RU-486	Patient hospital	ized
Patient received a transfusion Severe bleedi	ino		
	· · · · · · · · · · · · · · · · · · ·		
Othor exercise proper females			
Other serious event (specify)			
_		***************************************	300000000000000000000000000000000000000
6. Duration of event: Hours	Days		
7. Remarks:	TO CHARLES AND A SECURITY OF THE SECURITY OF T		
hacan	pricated such	à	
8. a. Name of physician who provided RO-48	6 Catherine	Romo	nos
8. b. Physician's signature			
o. b. thysician's signature	X	A . / / / / /	100.
	Date	4/30/2	A STATE OF THE STA
Send completed forms to: State Me	edical Board of Ohio	······	An and a second of the second
Legal Departme	nt		

30 E. Broad St., 3rd Floor

MAY 1 0 2021



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 HU-48E

1. Date RU-486 was provided:	Ц	a	8021
	Month	Day	Year
2. Name of medical practice or facility at v	which RU-486 was prov	vided:	
Women's Med Dayton			
3. Address of medical practice or facility at 1401 E Stroop Rd	t which RU-486 was pro	ov ded:	
Dayton, Ohio 45429			
4. Date post RU-486 complication began:	4/19/20	21	
5. Event(s) (Please check all that apply):			the state of the s
Incomplete abortionA	dverse reaction to RU-485	Patient hospitaliz	e d
Patient received a transfusion Severe ble	eding		
Other serious event (specify)			
6. Duration of event: Hours	Days		The state of the s
7. Remarks:	uncomplicati	ed suctra	
8. a. Name of physician who provided RU-	486 Br. Artheri	ne Doman	105
8. b. Physician's signature	Date		200 U/30/21
	W 100 100 100 100 100 100 100 100 100 10		-11-25-12/

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor



MEDICAL BOARD MAR 2 9 2021

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	2	25	2021
	Month	Day	Year
Name of medical practice or facility at which I Women's Med Dayton	RU-486 was provided	j	
3. Address of medical practice or facility at which 1401 E Stroop Rd Dayton, Ohio 45429	i RU-486 was provide	eď:	
	3/11/2021		
5. Event(s) (Please check all that apply):			
Incomplete abortion Adverse r	reaction to RU-485	Patient hospitalized	
Patient received a transfusion Severe bleeding			
Other serious event (specify)			
6. Duration of event: Hours	_ Days		
7. Remarks: CMCMylicate	ed DaC		
8. a. Name of physician who provided RU-486 8. b. Physician's signature Date	Seann 3/16	e Corw	The state of the s
Send completed forms to: State Medica	al Roard of Obio	Control of the Contro	

Legal Department

30 E. Broad St., 3rd Floor



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	/	5	27
	Month	Day	
2. Name of medical practice or facility Planned Parenthoo		vided:	
2 Address & Facility	ituat whis DI 1 10C was	zerinleselen er weren er	
2314 Auburn Au			
4. Date post RU-486 complication beg $2///2/$	gan:		
5. Event(s) (Please check all that apply	/):		
[n	Adverse reaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion Sever	re bleeding		
Other serious event (specify)			
6. Duration of event: 3 Am Hour	s Days		
7. Remarks:			
The marks.			
•			
8. a. Name of physician who provided	RU-486 /)	- Bidale	
8. b. Physician's signature	() / -	. 0.000	
o, o., mysician s signature	Date	(30/21	D.O
Send completed forms to: Sta	ate Medical Board of Ohio		
Legal Depa			MEDICAL BOAR APR 05 2021
	d St., 3 rd Floor		WEDICAL
	OH 43215-6127		APR 05 MILL



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided BU-485

1. Date RU-486 was provided:	03 16 2021 Month Day
Name of medical practice or facility at Women's Med Dayton	200
3. Address of medical practice or facility: 1401 E Stroop Rd	at which RU-486 was provided:
Dayton, Ohio 45429	
4. Date post RU-486 complication began:	03-23-2021
5. Event(s) (Please check all that apply):	
Incomplete abortion	Adverse reaction to RU-486 Patient hospitalized
Patient received a transfusion Severe b	leeding
Other serious event (specify)	
6. Duration of event: Hours	Days
7. Remarks:	
8. a. Name of physician who provided Rt. 8. b. Physician's signature	Date 3/26/2021
end completed forms to: State	Medical Board of Objo

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

MAR 3 1 2029



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided Ru-485

1. Date RU-486 was provided:	3	4	2021
Name of medical practice or facility at whi Women's Med Dayton	Month ch RU-486 was provid	bay ded:	Year
3. Address of medical practice or facility at wi 1401 E Stroop Rd Dayton, Ohio 45429	hich RU-486 was prov	/ded:	
4. Date post RU-486 complication began:	3/2/2021	***	
5. Event(s) (Please check all that apply): Incomplete abortion Adver- Patient received a transfusion Severe bleeding	rse reaction to RU-486	Patient hospitalize	ď
Other serious event (specify)			
6. Duration of event:Hours 7. Remarks:	THE RESERVE OF THE PROPERTY OF		Problems of the second
8. a. Name of physician who provided RU-486 8. b. Physician's signature Depend completed forms to:	Louthen ate	ne Roman	7 <i>OS</i>

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

MAR 3 1 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	2	5	- 2/
	Worth	Day	Year
2. Name of medical practice or facility at which	RU-486 was provi	ded:	
Women's Med Dayton			
3. Address of medical practice or facility at which 1401 E Stroop Rd	n RU-486 was prov	v'ded:	
Dayton, Ohio 45429			
4. Date post RU-486 complication began:	2 9 6	2/	
5. Event(s) (Please check all that apply):			And the state of t
Incomplete abortion Adverse r	reaction to RU-485	Patient hospitalize	<u>.</u>
Patient received a transfusion Severe bleeding			
Other serious event (specify)			
6. Duration of event: Hours	_ Days		
7. Remarks:	The North Societies Control of the C		
8. a. Name of physician who provided RLJ-486	Couher	me lom	anes
8. b. Physician's signature Date			11/21
			20 MATE 100 MATE 1

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

FEB 2 2 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided Ru-485

1. Date RU-486 was provided:		X	21
	Month	Day	Year
2. Name of medical practice or facility at whi	ich RU-486 was provi	ded:	1 Cycles
Women's Med Dayton	·		
3. Address of medical practice or facility at wind 1401 E Stroop Rd	hich RU-486 was prov	/ded:	
Dayton, Ohio 45429			
4. Date post RU-486 complication began:	2/16/6	21	and the second s
5. Event(s) (Please check all that apply):	**************************************	30-00-00-00-00-00-00-00-00-00-00-00-00-0	and the state of t
Incomplete abortion Adver	rse reaction to RU-486	Patient hospitalize	xĠ
Patient received a transfusion Severe bleeding	ig		
Other serious event (specify)			ээт тайгайн ханган хангаа
6. Duration of event: Hours	Days		We percentile the state of the
7. Remarks:	\$ \$40,000 miles \$10,000 mile	Charles and the second	
3. a. Name of physician who provided RU-486	Carhori	re Roman	YES-
3. b. Physician's signature	Pate		00 8 /81
end completed forms to:	Market Wareham		

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

MAR 0-1 2021



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:		2	<u></u>	0.1
		Month	Day	21
2. Name of medical practice or face Planned Parenthe	cility at which R	U-486 was prov	<u> </u>	. Year
3. Address of medical practice or fa	acility at which	RU-486 was pro	vided:	
2314 Auburn A				
4. Date post RU-486 complication by $2 1 2 $	pegan:			
5. Event(s) (Please check all that ap	pply):			
✓ Incomplete abortion	Adverse rea	ection to RU-486	Patient hospitaliz	ed
Patient received a transfusion Se	evere bleeding			
Other serious event (specify)				
6. Duration of event: 2 Ho	ours	Days		
7. Remarks:				
۸.				
3. a. Name of physician who provide	ed RU-486	Dr.	Pinsak	
3. b. Physician's signature		2	MD	00
	Date –	2	124/2	
end completed forms to:	State Medical E	Board of Ohio		
Legal D	epartment			MED.
30 E. Br	road St., 3 rd Floo	or		CUICAL BOA
Columb	ous, OH 43215-	6127		MEDICAL BOAR



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	1	22	21
	Month	Day	Year
2. Name of medical practice or facility at whe	ich RU-486 was provid	led:	
3. Address of medical practice or facility at w			
4. Date post RU-486 complication began: 3 2 4			
5. Event(s) (Please check all that apply): Adve	erse reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe bleedi Other serious event (specify) 6. Duration of event: 3 Hours			

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	12	29	20
WAY TO THE PARTY OF THE PARTY O	Month	Day	Year
2. Name of medical practice or facility at wh Planned Parenthood	nich RU-486 was provi	ded:	
3. Address of medical practice or facility at w	The state of the s		
4. Date post RU-486 complication began:			1
5. Event(s) (Please check all that apply): ———————————————————————————————————	erse reaction to RU-486	Patient hospitalize	d
Other serious event (specify)	ing		<u>-</u>
Other serious event (specify)			

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	3	3	21
	Month	Day	Year
2. Name of medical practice or facility at w Planned Parenthood	vhich RU-486 was provid	ed:	
3. Address of medical practice or facility at 2314 Auburn Au.			
4. Date post RU-486 complication began: $4/8/4$			
5. Event(s) (Please check all that apply):		Patient hospitalize	ed
6. Duration of event: Hours	Days		
7. Remarks:			16. 16.
3.			

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

APR 2 1 2021

Required pursuant to R.C. 2919.125

To be completed by the physician who provided RU-486

1. Date RU-486 was provi	dea:	September	23	2020
		Month	Say	*ear
	Preterm, Inc.	485 was provided	:	
	tise or facility at which RU Boulevard,			44 120
4. Date post RU-486 comp	lication began:	C Perecuna ,	V III V	
1/28/202 5. Event(s) (Please check a	II that apply):Adverse react	don to Ru-485	Patient nospita	ited .
Patient received a transfusi	on Severa bleeding			
Other serious event (specify 5. Duration of event:	۲) Hours D	avs		
or Daragon on Event.		cys		
7. Remarks: Patient abortion guid 3. a. Name of physician wh 3. b. Physician's signature		ompliant of take home prompted in Mitchell		
	Date 4			
end completed forms to	State Medical B	pard of Ohio		
	Lega Department			
	30 E. Broad St., 3 rd F 50			
-	Co umbus D4 4321546			MEDICAL BOAT

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Reduired burguan; to F.C. 2918, 128

	ov dea:	September	23	2020
		Month	ī.a.	hear
2. Name of medical prac	ctice or facility at which Pl Preterm, Inc.)-485 was provides;		
	astise or facility at which R			
12000 O haker	Boulevard,	Cleveland,	Ohio	44 120
4. Date post KU-486 com	iplication began:			
1/28/20 5. Event(s) (Please check	all that apply):			
Incomplete abortion	Adverse read	ರವರಗ ಕರ ಸಿಎ-48ಕಾ	atient nospita	ited .
Patient received a transfus	sion Severe bleeding			
Other serious event (specif	55°)	•		
. Duration of event:	Hours 3	Jays		
3	- cuas non-c	ompliant w	ith med	dication
Remarks: Patient abortion guio	delines, did not t	take home pre	gnancy te	st.
Remarks: Patient Government Government Guio a. Name of physician who b. Physician's signature		Mitchell		
a. Name of physiciar wh	nc provided RU-486	Mitchell	Reider	
a. Name of physician wh b. Physician's signature	nc provided RU-486 MRcile	Mitchell	Reider	
a. Name of physician wh b. Physician's signature	nc provided RU-486 MRaide Date —	Mitchell	Reider	
a. Name of physiciar wh	no provided RU-486 MRai De Date — State Medical Sc	Mitchell Spard of Onle	Reider	



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	1	22	21
	Month	Day	Year
2. Name of medical practice or facility at whe	nich RU-486 was provid	led:	
3. Address of medical practice or facility at w 2314 Auburn Am. (
4. Date post RU-486 complication began:	100071	17/28	
5. Event(s) (Please check all that apply):			
Adve	erse reaction to RU-486	Patient hospitalized	i
Adve Patient received a transfusion Severe bleedin Other serious event (specify)		Patient hospitalized	1
Patient received a transfusion Severe bleeding	ng	Patient hospitalized	1
Patient received a transfusion Severe bleedin Other serious event (specify)	ng	Patient hospitalized	

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	12	29	20
	Month	Day	Year
2. Name of medical practice or facility at v Planned Parenthood	vhich RU-486 was provi	ded:	
3. Address of medical practice or facility at	which RU-486 was prov	vided:	
2314 Auburn Aus.	ana, of	45219	
4. Date post RU-486 complication began:		***	*******
5. Event(s) (Please check all that apply):			
10	atherina (Control Control Cont		
Ad	verse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe blee	ding		
Other serious event (specify)			
31(3)			
5. Duration of event: Hours	20_Days		
7. Remarks:	9100	100	
. Nemarks.			
3	150.5		
a. Name of physician who provided RU-48	36 A Do	Kalsy	
b. Physician's signature	Mach	MD/D	
of thysician s signature	- flux	/ ND1/1	10
	Date 4/1	3/21	2.0

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	3	3	21
134	Month	Day	Year
2. Name of medical practice or facility at whi Planned Parenthood	ch RU-486 was provid	ded:	
3. Address of medical practice or facility at wh			-
2314 Auburn Aue. C	ina, of	45219	
Date post RU-486 complication began: $4/8/H$			
Event(s) (Please check all that apply): Incomplete abortion failedAdverse		41	
Advers	se reaction to RU-486	Patient hospitalized	d
Patient received a transfusion Severe bleeding			
	Š		
Other serious event (specify)			
The same of the sa		and the second s	
Duration of event: Hours	Days		1 Hardware Charles Control of the Co
Remarks:			
nemarks:			
a. Name of physician who provided RU-486		in	
o. Physician's signature			
V	4/	a/M M.D./I	0.0
Da	te	7/0/	

Legal Department 30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	april	24	Q0Q1
	Month	Day	Year
2. Name of medical practice or facility at which	RU-486 was provi	ded:	
Women's Med Dayton			
3. Address of medical practice or facility at whice 1401 E Stroop Rd	h RU-486 was pro	vided:	
Dayton, Ohio 45429			
4. Date post RU-486 complication began:	5/3/2021		- TOTAL TOTA
5. Event(s) (Please check all that apply):			
Incomplete abortion Adverse	reaction to RU-485	Patient hospitalize	tď
Patient received a transfusion Severe bleeding			
Other serious event (specify)			· ·
6. Duration of event: Hours	Days	- Control of the Cont	
7. Remarks:			
uncer	probled Snatte	u	
8. a. Name of physician who provided RU-486	Cost	ossino de	200000
8. b. Physician's signature	le		5/4/2021
Send completed forms to: State Medic	cal Board of Ohio		- Contract to the state of the

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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

MEDICAL BOWN

MAY 2 4 2021



JUN 0 2 202

(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	_ 4	6	21
	Month	Day	Year
2. Name of medical practice or facility a Planned Parenthood	at which RU-486 was prov	vided:	
3. Address of medical practice or facility	at which RU-486 was pro	ovided:	
2314 Auburn Aus.	ana, of	45219	
4. Date post RU-486 complication began	:		
5. Event(s) (Please check all that apply):			
ncomplete abortion	Adverse reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe b	oleeding		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks: Completed Sary certing			
3. a. Name of physician who provided RU	J-486)r Pickle	
3. b. Physician's signature	Date \ 5/25/	M.D./	D.O
end completed forms to: State	Medical Board of Ohio		
Legal Depart	ment		
30 E. Broad S	St., 3 rd Floor		
Columbus, O	H 43215-6127		



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	6	10	21
	Month	Day	Year
2. Name of medical practice or fac	cility at which RU-486 was prov	vided:	
Women's Med Dayton			
3. Address of medical practice or fi 1401 E Stroop Rd	acility at which RU-486 was pro	ovided:	
Dayton, Ohio 45429			
4. Date post RU-486 complication	began: 7/14/2		
5. Event(s) (Please check all that a	pply):		
✓ Incomplete abortion	Adverse reaction to RU-485	Patient hospitali	zed
Patient received a transfusion 5	Severe bleeding		
Other serious event (specify)		***	
6. Duration of event:	Hours Days		
7. Remarks:	Suction (und	complicated	,(,)
8. a. Name of physician who provi	ided RU-488 COUN	erine Ro	nanos
8. b. Physician's signature —	Date 7),00-
Send completed forms to:	State Medical Board of Ohi		DICAL BOARD
	al Department	IVIE	
30 E	. Broad St., 3 rd Floor		JUL 2 2 2021

Columbus, OH 43215-6127

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



(Required pursuant to R.C. 2919.123)

Date RU-486 was provided:	July	12	2021
120	Month	Day	Year
Name of medical practice or facility Women's Med Dayton	at which RU-486 was provi	ided:	-
3. Address of medical practice or facility 1401 E Stroop Rd Dayton, Ohio 45429			
4. Date post RU-486 complication bega	m: M-22-202	1	
5. Event(s) (Please check all that apply)	Adverse reaction to RU-486	Patient hospital	ized
Other serious event (specify)			
6. Duration of event: Hours	s Days		
7. Remarks:			
8. a. Name of physician who provided 8. b. Physician's signature	RU-486 Jeann Date 7	27/20	/00
Send completed forms to: Sta	ate Medical Board of Ohio		
	ad St., 3'd Floor	WEDIC	AL BOARD
	s, OH 43215-6127	AUC	0 9 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	July Month	22 Day	2021 Year
Name of medical practice or facility as Women's Med Dayton	t which RU-486 was provi	ded:	
3. Address of medical practice or facility 1401 E Stroop Rd	at which RU-486 was pro	vided:	, , , , , , , , , , , , , , , , , , , ,
Dayton, Ohio 45429 4. Date post RU-486 complication began	July 27	,2021	-
Event(s) (Please check all that apply): Incomplete abortion	Adverse reaction to RU-486		alized
Patient received a transfusion Severe b			
1	Days		
7. Remarks:	1		
8. a. Name of physician who provided R 8. b. Physician's signature	Date Cotherin	u Roman	os MD
Legal Depa	te Medical Board of Ohio irtment d St., 3 rd Floor	ME	DICAL BOARD



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	7		22	21
	Month	100000	Day	Year
Name of medical practice or fac Women's Med Dayton	cility at which RU-486 wa	s provided:	- A	
3. Address of medical practice or fa 1401 E Stroop Rd Dayton, Ohio 45429	acility at which RU-486 w	vas provideo	3:	
4. Date post RU-486 complication	began: 7/8	18/21	10	
S. Event(s) (Please check all that a position incomplete abortion Patient received a transfusion incomplete serious event (specify) incomplete abortion incomplete a	Adverse reaction to R	(U-485	Patient hospitalize	d
6. Duration of event:	Hours Days			
7. Remarks:				111
8. a. Name of physician who provi 8. b. Physician's signature	ded RU-486	hero	7/29	nanos 100
	State Medical Board of Department	of Ohio	MEDICAL	BOARD

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

AUG 0 2 2021

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



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	6	2	21
	Month	Day	Year
2. Name of medical practice or facility at who Planned Parenthood	ich RU-486 was provid	ded:	Dec. (amp.)
3. Address of medical practice or facility at w	hich RU-486 was prov	rided:	
2314 Auburn Au. C	ana, of	45219	
4. Date post RU-486 complication began: \mathcal{H} 13 \mathcal{H}			
5. Event(s) (Please check all that apply):	erse reaction to RU-486	Patient hospitalize	ed
6. Duration of event:3 Hours	Days		
7. Remarks:			

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MENICAL HOARD



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	6	23	21
	Month	Day	Year
2. Name of medical practice or facility at a Planned Parenthood	which RU-486 was prov	ided:	
3. Address of medical practice or facility at 2314 Auburn Au.			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):	dverse reaction to RU-486 eding	Patient hospitalize	d
6. Duration of event:2_ Hours	Days		
7. Remarks:			
3. a. Name of physician who provided RU-4	Alacy Date 7	Dr. Kalsy MD)	D.O
end completed forms to: State I	Medical Board of Ohio		

Columbus, OH 43215-6127

MEDICAL BOARD AUG 0 2 2021



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:		5	20	21
N/ 07/01/201		Month	Day	Year
2. Name of medical practice or face Planned Parentho	Λ	186 was provi	ded:	
3. Address of medical practice or fa	cility at which RU	-486 was pro	vided:	
2314 Auburn A	w. ana	, 0+1	45219	
4. Date post RU-486 complication b				
5. Event(s) (Please check all that ap	ply):			
Incomplete abortion	Adverse react	ion to RU-486	Patient hospital	ized
Patient received a transfusion Se	vere bleeding			
Other serious event (specify)				
10-10-1				ni-
6. Duration of event:3_H	ours D	ays		
7.0	77,000			
7. Remarks:				
15				
3. a. Name of physician who provide	ed RU-486		Dr. Pers	ch
B. b. Physician's signature			,M.D	100
	Date —	7/23/2	1	-
send completed forms to:	State Medical Bo	oard of Ohio		
	Department			MEDICAL
30 E. B	broad St., 3 rd Floor			AUG 0 2 2021
Colum	bus, OH 43215-6	127		MUU U Z ZUZI



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	4 Month	J Day	¥
2. Name of medical practice or facility at which R Planned Parent hood	U-486 was prov	ided:	Year
3. Address of medical practice or facility at which 2314 Aubun Am.			
4. Date post RU-486 complication began: $\sqrt{28/2}$			
5. Event(s) (Please check all that apply):			
Adverse re	eaction to RU-486	Patient hospitalized	ł
Patient received a transfusion Severe bleeding			
Other serious event (specify)			
6. Duration of event: Hours	_ Days		
7. Remarks:			
8. a. Name of physician who provided RU-486	<u> </u>	c. har	
8. b. Physician's signature	6/	10/2/	0.0
end completed forms to:		/	

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

JUN 2 1 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	۲(2.2	21
	Month	Day	Year
2. Name of medical practice or facility at whice Planned Parenthood	th RU-486 was pro	vided:	
3. Address of medical practice or facility at wh	ich RU-486 was pi	ovided:	
2314 Auburn Aus. Ca	ina, of	45219	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Incomplete abortion Advers	e reaction to RU-486	Patient hospitalize	ď
Patient received a transfusion Severe bleeding	5		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:			
•			
8. a. Name of physician who provided RU-486	nDc	Kalsy	
8. b. Physician's signature	naly te M	they 6/10/6	D.O 9-/
and completed forms to			

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor Columbus, OH 43215-6127 MEDICAL BOARD JUN 2 1 2021

(Required pursuant to R.C. 2919,123)

	<u> </u>				
1. Date RU-486 was provide	ed: ·	6	20)	21	
C		Month	Day	Year	
2. Name of medical practice	e or facility at which RU	J-486 was prov	ided:		
NORTHEAST OHIO V					
3. Address of medical practs 2127 STA CUYAHOGA FAL		RU-486 was pro	vided;	· [=
4. Date post RU-486 compli	cation began:	,	·		
5. Event(s) (Please check all	that apply):	•			
2. K Incomplete abortion	Adverse rea	action to RU-486	Patient hospitalized		-
Patient received a transfusion	n Severe bleeding	Fad.	of above		
Other serious event (specify)					·
6. Duration of event:	Hours	Days			
7. Remarks: A L	Lyeren h	perense	es. I wholly	delno	•
Jan Die	8 comple	cala ag	14/25/DI		
8. a. Name of physician who	provided RU-486	David	M Garka)	
8. b. Physician's signature	Date	4/20	M 2/1	.o	4
Shift form plated forms to		Board of Ohio	1 .		
Send completed forms to:		OINU 10 DIBOC I			
	Legal Department		MEDICAL	BOARD	
	30 E. Broad St., 3 rd Fl				
	Columbus, OH 4321	5-612 7	n 11 0	6 2021	

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

2. Name of medical practice or facility at which RU-486 was provided: Vor Chane Walthau UC 3. Address of medical practice or facility at which RU-486 was provided: 67	1. Date RU-486 was provided:	June	. 8	2021	
Nov Chance Workhame UC 3. Address of medical practice or facility at which RU-486 was provided: 6721 Wav1 Rd. Columbras Sul 43229 4. Date post RU-486 complication began: 6120 21 5. Event(s) (Please check all that apply): 9. Facility 1. Incomplete abortionAdverse reaction to RU-486Pattent hospitalized Pottent received a transfusion Severe bleeding Other serious event (specify) 6. Duration of event: Hours Days 7. Remarks: Failed mAB. 2 Uternal palint for airgul AB are another facility. 8. a. Name of physician who provided RU-486 L. A. Annady ww 8. b. Physician's signature MDDD.0		Month	Day	Year	
3. Address of medical practice or facility at which RU-486 was provided: 6721 Wav1 Rd. Columbus Ol 43229 4. Date post RU-486 complication began: 6130 21 5. Events() Please check all that apply): 1		•	ed;		
4. Date post RU-486 complication began:	Your Chane Karttua	ne uc		٠.	
4. Date post RU-486 complication began: 6/30/21					
4. Date post RU-486 complication began: 6/30/2/ 5. Event(s) (Please check all that apply): Facture Patient hospitalized Patient hospitalized Patient received a transfusionSevere bleeding Other serious event (specify) 6. Duration of event: Hours Days 7. Remarks: Failed mAB. 2 Chernal palint for airgal AB at another factory. 8. a. Name of physician who provided RU-486 L. A. Nanady male MDD.0	3. Address of medical practice or facility a	t which RU-486 w	ras provided:		
5. Event(s) (Please check all that apply): Failul	6721 Kavl Rd.	Columbus	od i	13229	
5. Event(s) (Please check all that apply): Latel Latel	4. Date post RU-486 complication began:				
5. Event(s) (Please check all that apply): Latel Latel	6130121				
Patient received a transfusion Severe bleeding Other serious event (specify) 6. Duration of event: Hours Days 7. Remarks: Failed mAB. 2 Hours palier for airgal AB at another Leating. 8. a. Name of physician who provided RU-486 L. A. Nanady male M.D.D.O			•		•
Patlent received a transfusion Severe bleeding Other serious event (specify) 6. Duration of event: Hours Days 7. Remarks: Failed mAB. 2chernel palint for any AB ar another facility. 8. a. Name of physician who provided RU-486 L. A. Ahmady male	failed		Dostova k souteat	hand.	
Other serious event (specify) 6. Duration of event: Hours Days 7. Remarks: Failed mAB. 2chernel palier for airgal AB are another facility. 8. a. Name of physician who provided RU-486 L. A. Nunnaly M.D.D.O	Incomplete abortionAdverse	: reaction to KU-486	ratient nospital	Keu	
Other serious event (specify) 6. Duration of event: Hours Days 7. Remarks: Failed mAB. 2chernel palier for airgal AB are another facility. 8. a. Name of physician who provided RU-486 L. A. Nunnaly M.D.D.O				•	
6. Duration of event:	Patient received a transhision Severe bleeding				
6. Duration of event:	0.1				
7. Remarks: Failed mAB. 2 chernel palint for airgal AB at another Lieuthy. 8. a. Name of physician who provided RU-486 L.A. Nunnaly MD 8. b. Physician's signature M.D.D.O.	Other serious event (specify)				
7. Remarks: Failed mAB. 2 chernel palint for airgal AB at another Lieuthy. 8. a. Name of physician who provided RU-486 L.A. Nunnaly MD 8. b. Physician's signature M.D.D.O_	_				
Failed mAB. 2 chernel palet for august 715 at answer Lieuth's. 8. a. Name of physician who provided RU-486 L.A. Nunnaly MD 8. b. Physician's signature M.D.D.O_	6. Duration of event: HoursO	Days			
Failed mAB. 2 chernel palet for august 715 at answer Lieuth's. 8. a. Name of physician who provided RU-486 L.A. Nunnaly MD 8. b. Physician's signature M.D.D.O_					
8. a. Name of physician who provided RU-486 L. A. Nunnaly M.D.D.O_	7. Remarks: Failed mAB 120	bound out	in for a	isal AB at	arde
8. a. Name of physician who provided RU-486 L. A. Nunnally M.D.D.O_		10.00	•	(
8. b. Physician's signature	Lecutes.				
8. b. Physician's signature			1 -1		·
	8. a. Name of physician who provided RU-	486 <u>L. /</u>	t. Nunna	y wo	
	. 9 h Dhusician's signature	1h		M Dn o	
vate	o. n. cuysician s signature	Data	10.20.21		
		vate	e : 50 · L/		
Send completed forms to: State Medical Board of Ohio	Send completed forms to:	.			

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD JUL 07 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided BU-485

1. Date RU-486 was provided:		(0	1/	2021
	Me	nth	Day	Year
2. Name of medical practice or facility a	t which RU-486	was provided		700000000000000000000000000000000000000
Women's Med Dayton				
3. Address of medical practice or facility 1401 E Stroop Rd	at which RU-48	б was provide	₽ď:	
Dayton, Ohio 45429				
4. Date post RU-486 complication began	: Cellel	2021		
5. Event(s) (Please check all that apply):				
Incomplete abortion	Adverse reaction (to RU-485	Patient hospitalized	d
Patient received a transfusion Severe b	leeding			
Other serious event (specify)	Mary Alexander			of the second se
6. Duration of event: Hours	Days			Makananan na mananan n
7. Remarks:	TO THE THE PERSON NAMED OF THE PERSON NAMED IN	The state of the s		
ur	ocmpliat	ed D:		
8. a. Name of physician who provided Rt	J-486	afhero	e Rom	anos
8. b. Physician's signature	Date	efueto		
Send completed forms to: State	■ Medical Board	l of Ohio		P. School and P. Control and P. Cont
Legal Depar	tment			
30 E. Broad	St., 3 rd Floor		v	

Columbus, OH 43215-6127

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



JUN 2 4 2021

(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	_05	28	2021
	Month	Day	Year
2. Name of medical practice or facility at v	which RU-486 was provid	led:	· · · · · ·
Women's Med Dayton			
3. Address of medical practice or facility at 1401 E Stroop Rd	which RU-486 was prov	ded:	
Dayton, Ohio 45429			
4. Date post RU-486 complication began:	6/1/2/	-	
5. Event(s) (Please check all that apply);			
Incomplete abortion At	dverse reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe ble	eding		
Other serious event (specify)			POLYTICA BASIC magazine.
6. Duration of event: Hours	Days		
7. Remarks:	and the state of t		
8. a. Name of physician who provided NU-	186 (ash)	Irine R	onianos
8. b. Physician's signature		(MD)/	DO.
	Date	10/3/	21
Send completed forms to: State i	Medical Board of Ohio	/ 200	
Legal Departn	ment		
30 E. Broad St	, 3 rd Floor	•	
Columbus, OF	H 43 215-6127		

JUN 2 4 2021



State Medical Board of Ohio Report of RU-486 Event

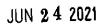
(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	\	3	12	al	
	Mor	•th	Day		
Name of medical practice or facility at v Women's Med Dayton	which RU-486	was provided:			
3. Address of medical practice or facility at 1401 E Stroop Rd	which RU-486	s was provided	i e		
Dayton, Ohio 45429					
4. Date post RU-486 complication began:	6/3/6	21	· · · · · · · · · · · · · · · · · · ·	**************************************	
5. Event(s) (Please check all that apply):			-,		
Incomplete abortionA	dverse reaction to	o RU-4861	Patient hospitalize	: ₫	
Patient received a transfusion Severe ble	eding				
Other serious event (specify)				The state of the s	
6. Duration of event: Hours	Days				•
7. Remarks;		10-10-10-10-10-10-10-10-10-10-10-10-10-1			
D: E	uncarpli	cuted.			
8. a. Name of physician who provided RU- 8. b. Physician's signature	Date	Catheri	. (MD)	omano:	S
Send completed forms to: State f	Medical Board	of Ohio			7900000 10.00
tegal Departn					
30 E. Broad St	., 3 rd Floor		•		

Columbus, OH 43215-6127

Prescribed, 5/--/2011, Rev. 17/23/22





(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	Old Month	04	2021
Name of medical practice or facility at w Women's Med Dayton		Day ided:	Year
3. Address of medical practice or facility at 1401 E Stroop Rd	which RU-486 was pro	ovided:	723700
Dayton, Ohio 45429 4. Date post RU-486 complication began:	6/9/21	Manufach est minimizer of the second of the	
5. Event(s) (Please check all that apply):			
Incomplete abortion Adv	verse reaction to RU-486	Patient hospitaliz	<u>e</u> d
Patient received a transfusion Severe bleer	ding		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:	E.		
8. a. Name of physician who provided RU-4: 8. b. Physician's signature		ne Roman	105 100
Send completed forms to: State M Legal Departme	ledical Board of Ohio		33004

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

	6	17	21
	Month	Day	Year
2. Name of medical practice or facility at w Planned Parenthood	vhich RU-486 was prov	ided:	4
3. Address of medical practice or facility at 2314 Auburn Au.			
4. Date post RU-486 complication began: しんよりみ	Maria I		
5. Event(s) (Please check all that apply):			
✓ Incomplete abortion Ad	verse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Severe blee	ding		
Other serious event (specify)			
6. Duration of event: Hours	Days		
6. Duration of event. Britis			
7. Remarks:		WAR TO THE PERSON OF THE PERSO	
		TOTAL PARTY. PARTY.	
7. Remarks:	86	Dr. Perse	
	86 Pate 7/15	Dr. Person	(D.O

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

JUL 26 2021

Repuired pursuant to F.C. 2919 123

1. Date RU-486 was provi	dea:	02	13	202
		Month	Jay	Year
2. Name of medical practi Preterm	se or facility at which Ri	J-486 was provis	ea:	
3. Address of medical prac				
12000 Shaker	Blvd. Clevela	and, OH	44120	
4. Date post RU-486 compl 2/24/				
5. Event(s) (Please check al	! that apply):			
recomplete abordion	Adverse rea	action to Ru-485	Patient nospita	a-ized
Patient rebelved a transfusion	or Severe bleeding			•
X Other serious event (specify	Failed Med	dication +	bortion	
6. Duration of event:	2 Hours . D	Days		
7. Remarks: Completed Su	rgically			
3. a. Name of physician who	provided RU-486	Mitche	II Reide	er .
3. b. Physician's signature	- MC	,	(M.)	> 50
iend completed forms to	State Medica	Spard of Drie		
	Lega Department			
	30 € Srcad St. 3 ⁷² = 5	0-		
-	Dolumbus DH 43223	212		MEDICAL BOARD

Reduired bursuant to 9.0. 2919,123.

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	03	03	2021
	Konth	Sav	ear
2. Name of medical practice or facility at v Pre-term	wnich PU-486 was provi	a€a: 	
3. Address of medical practice or facility at	·		
12000 Shaker Bivd. (Cleveland, C	H 44120	
4. Date post RU-486 complication began: $03/11/2021$			
5. Event(s) (Please check all that apply):			
x.rcomplete abortion Ad	averse reaction to Ru-485	Patient nospita is	ec ₋
Patient received a transfusion Severe ple	eding		
Other serious event (specify)	. •		
5. Duration of event: 2 Hours _	O Days		
7. Remarks: D+C completed on	03/11/2021	<u>_</u>	
D+C completed on	00/11/2001		
i. a. Name of physician who provided Ri $oldsymbol{n}$	186 Mitc	hell Rejo	ler
l. p. Physician's signature	NK		<u> </u>
end completed forms to: State I	Vegical Board of Onlic		
lega Departm	nent		
30 E. Broad St	. 3 ^{rt} = por		

. Thuisteen 1 - 15**71**1 Awy 11 1 11

Reduired pursuant to F..C. 2919,123

1. Date RU-486 was provi	dea:	03	17	2021
		f, to the	Dav	· 6 2°
Name of medical pract	fice or facility at whic	th RU-486 was pro	viaea:	
Preterm				
. Address of medical prac				
12000 Shak	rev Blvd. C	leveland,	OH 44120)
. Date post RU-486 comp	olication began:			
03/23/				
5. Event(s) (Please check a	al' that apply):			
: incomplete aportion	Agueri	se reaction to Ru-486	Dationt normital	inad
	AGVE	e saudo (0 5,21400)	rasent nusolta	
Patient received a transfusi	ion Severe bleeding	5		
	- 11		. 1	
🗶 Other serious event (specifi	y Failed K	nedication	Abortion	
	0 -			
. Duration of event:	∠_Hours	Days		
. Remarks:		1		
Complete	ed surgical	lej		
. ,	V	V		
		m.i	-010 a (1 M o)	2/01/
. a. Name of physician wh	ic provided RMARS	$2^{-\frac{1117}{2}}$	chell Rei	cer
b. Physician's signature) = 0
	Da	ete		
end completed forms to	State Med	ical Board of Onic		
	Lega Department			
	30 E. Broad St. 3 ^r	E por		
-	Columbus DH 43	115-6127		

Reduired pursuant to F.C. 2919.123.

1. Date RU-486 was provi	ded:	00	09	2021
	6	N'artr	2av	\ear
2. Name of medical practi	ce or faculty at which	FU-486 was provi	aed:	
3. Address of medical prac		, '		
12000 Shalks	er Blud. Cle	weland, or	4 44120	
4. Date post RU-486 comp	lication began: 5/2021			
5. Event(s) (Please check a	ll that apply):			
incomplete abortion	Adverse	reaction to Ru-486	Patient nospitali	ced .
Patient received a transfusi	or Severe bleeding			
A Other serious event ispecify	Failed n	udication	Abortion	<u> </u>
6. Duration of event:	2 Hours 0	Days		
7. Remarks:	4.0			
completed	surgically			
8. a. Name of physician wh	c provided RU-4€6∧	1 Mitch	hell Reide	21
8. p. Physician's signature			(F)	<u>):</u>
	V Dat	£		
Send completed forms to:	State Medic	a Board of Onic		
	Legal Department			
	30 E. Broad St. B ^{ro}	F 991		
-	to umbus de det	15-612		

Reduired pursuant to FLC 2919 123

1. Date RU-486 was provid	ed:	<u>03</u>		2021
2. Name of medical practic Preterm	e or facility at which P	U-485 was provid		
3. Address of medical pract				
4. Date post RU-486 compli 03 16 20				
5. Event(s) (Please check al!	that apply):			
X :ncomp ete aportion	Adverse re	eaction to RU-486	Patient noscita'	iced .
Patient received a transfusion	Severe bleeding			
Other serious event (specify)				
6. Duration of event: $=$ $\stackrel{ extstyle 2}{\sim}$	Hours 0	_ Days		
7. Remarks: D+C Comp B. a. Name of physician who B. b. Physician's signature	leted on 03			<u>r</u>
	Date			
end completed forms to:		Spard of Onic		
	Lega Department			
	30 E. Broad St. 3 rd Fi			
-	Columbus OH 43213	5-6127		

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:				
	Month	Day	Year	
2. Name of medical practice or facility at which	RU-486 was provid	led:		
3. Address of medical practice or facility at	t which RU-486 w	vas provided:		
4. Date post RU-486 complication began:				
5. Event(s) (Please check all that apply):				
Incomplete abortionAdverse	reaction to RU-486	Patient hospitalized		
Patient received a transfusion Severe bleeding				
Other serious event (specify)				
6. Duration of event: Hours	Days			
7. Remarks:				
8. a. Name of physician who provided RU-4	186			
8. b. Physician's signature			M.D/D.O	
	Date			

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

Date RU-486 was provided:	Month	. 14	2021	
	1414-1-1-	,	Year	
2. Name of medical practice or facility at which RU	-486 was provid	ed:		
Your Choice Kaltrine	<i>LCC</i>	·		
3. Address of medical practice or facility at w	hich RU-486 v	vas provided:		
6721 Karl Bond		•		
Columbus or 43229		11.00		
4. Date post RU-486 complication began:				
June 18, 202	1			
Event(s) (Please check all that apply):		•	•	
Incomplete abortionAdverse real	action to RU-486	Patlent hospitalize	i	
Patient received a transfusion Severe bleeding	•		·	
Other serious event (specify)	·			
6. Duration of event: Hours Da	ays .			
7. Remarks: Failed MAB. P. a.	in elect	ing to con	rue presnary.	· · · · · · · · · · · · · · · · · · ·
	.c. 1 /	Ann Nulsa	elm MD	
8. a. Name of physician who provided RU-48	6 <u> </u>	tan Nuni		<u> </u>
8. b. Physician's signature	Date	6.18.21	M.D.O	

Send completed forms to: -

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

JUN 2 3 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	\$	<u></u>	21
		Day	Year
2. Name of medical practice or facility at Planned Parenthood	which RU-486 was prov	vided:	
3. Address of medical practice or facility at	t which RU-486 was pr	ovided:	
2314 Auburn Aue.	ana, of	45219	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Incomplete abortion A	dverse reaction to RU-486	Patient hospitalize	d
Patient received a transfusionSevere ble	eding		
Other serious event (specify)			
6. Duration of event: Hours			
7. Remarks:			
٧.			
8. a. Name of physician who provided RU-4	186	c. Kalsiz	
8. b. Physician's signature	Date	7/7/2 (M.D.)	D.O
Send completed forms to: State N	Medical Board of Ohio		

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

JUL 12 2021



MEDICAL BOARD JUN 2 3 2021

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	4	16	¥
	Month	Day	Year
2. Name of medical practice or facil	/i	vided:	
3. Address of medical practice or fac	ility at which RU-486 was pr	ovided:	
2314 Auburn Au	u. ana, oH	45219	
4. Date post RU-486 complication be	egan:		
5. Event(s) (Please check all that app	ly):		
	Adverse reaction to RU-486	Patient hospitalized	đ
Patient received a transfusion Sev	ere bleeding		
Other serious event (specify)			
6. Duration of event: Hor	ırs Days		
7. Remarks:			
١.		0 .	
8. a. Name of physician who provided		final	
8. b. Physician's signature		<u> </u>	0.0
	Date	4/17/21	
Send completed forms to:	tate Medical Board of Ohio		
Legal De	partment		
30 E. Bro	ad St., 3 rd Floor		

Columbus, OH 43215-6127

(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provide	ed:	3		21
		Month	Day	Year
2. Name of medical practice Planned Pune				
3. Address of medical practi	ce or facility at which	RU-486 was pr	ovided:	
3255 E. Mai	in St Colu	mbus,	04 4321	3
4. Date post RU-486 compli	cation began: 3項. ~【			
5. Event(s) (Please check all	that apply):			
Incomplete abortion	Adverse n	eaction to RU-486	Patient hospitali	zed
Patient received a transfusion	n Severe bleeding			
Other serious event (specify)				
6. Duration of event:	Hours	_ Days		
7. Remarks: Mab wa US on 3.29.2 was performed	o initiated of therealed of 4.2.21;			on 3.1.21. 16. Aspiration
8. a. Name of physician who	provided RV/488	pr. M	c Chuney	
8. b. Physician's signature	Date	1 6/21/	2021 MD	£0
Send completed forms to:	State Medica	l Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd Fl	oor	MED	ICAL BOARD
	Columbus, OH 4321	5-6127	Δ	UG 1 7 2021

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	Ч	21	21
	Month	Day	Year
2. Name of medical practice or facility at which Planned Parenthood 0			
3. Address of medical practice or facility at which 3255 E. Main St. Columb			
4. Date post RU-486 complication began:	4.29.2		
5. Event(s) (Please check all that apply):			
Incomplete abortion Adverse	e reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe bleeding			
Other serious event (specify)			
6. Duration of event: Hours			
7. Remarks: Mab procedure lints Phone call on 4.29.21 Pt sta The realed continuing pr was performed 5.3.21; A	iated fer tites she wen egnancy. L. did well	THER . I Surgical C Post-op.	ren on 4.21.2 15 on 4.29.21 15 piration
8. a. Name of physician who provided RU-486/	Dr. L	owther	
8. b. Physician's signature Dat	t. (27/2)	MD)	2.0
Send completed forms to: State Medic	cal Board of Ohio		

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

AUG 1 7 2021



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provid	ed:	5	14	21
		Month	Day	Year
2. Name of medical practic	e or facility at which R	U-486 was prov	Phi 0	
3. Address of medical pract	ice or facility at which	RU-486 was pro	ovided:	
25350 Porka	ide Ru Bu	ed ford t	Hs, of u	1146
4. Date post RU-486 compl	ication began:	21		
5. Event(s) (Please check al	l that apply):			
Incomplete abortion	Adverse r	eaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion	on Severe bleeding			
Other serious event (specify)			
6. Duration of event:				
7. Remarks: Mal proportion of the Columbia. Pt as has been selected by the columbia.	xt ruterred to	OEK.		Gimen per Pro Ng. hS revale tinued bleedi
8. a. Name of physician wh	o provided RU-486	br. 1	1 decens	
8. b. Physician's signature	Date	wy	(M.D)	/ D.O
Send completed forms to:	State Medica	al Board of Ohio		
	Legal Department		MEDI	
	30 E. Broad St., 3 rd F	loor	IA	JG 1 1 LULI
	Columbus OH 4321	15 6127		



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provid	ed:	5	+		21
		Month	Day		Year
2. Name of medical practice	te or facility at which RU	486 was provi	ded:		
3. Address of medical pract	ice or facility at which R	U-486 was pro	vided:		
25350 Rockisi	de Pd. bedfo	nd HBO	+ umy	P	
4. Date post RU-486 compl	ication began: 6.15.21				
5. Event(s) (Please check al	I that apply):				
Incomplete abortion	Adverse rea	ction to RU-486	Patient hosp	oitalized	
Patient received a transfusion Other serious event (specify	200	ns.			
6. Duration of event:	Hours	Days			
7. Remarks: Mab was Ptcalled when the continuous contin			very.	en comme	
Send completed forms to:	Date/- State Medical				
The completed forms to	Legal Department			ME	DICAL BOARD
	30 E. Broad St., 3 rd Flo	or			
	Columbus, OH 43215			3	AUG 1 7 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

 Date RU-486 was provided 	:	7	2	2021
		Month	Day	Year
2. Name of medical practice of Women's Med Dayton		ch RU-486 was provid	ded:	
3. Address of medical practice 1401 E Stroop Rd	or facility at wh	nich RU-486 was prov	rided:	
Dayton, Ohio 45429				
4. Date post RU-486 complicat	tion began:	8-9-2	021	
5. Event(s) (Please check all th	at apply):		A.	45
✓ Incomplete abortion	Adver			
	wove.	se reaction to RU-486	Patient hospitalize	d
Patient received a transfusion	Severe bleedin	e		
		D.		
Other serious event (specify)				
	1100		****	
6. Duration of event:	Hours	Days		
7. Remarks:				
	\tilde{b} C .			
), C .			
		0	0	
3. a. Name of physician who pr	ovided RU-486	Cathe	me Kor	vanos
B. b. Physician's signature)
A CONTRACTOR OF THE CONTRACTOR	0		Selin	1/2 /
		ate	0/10	10)
end completed forms to:		ical Board of Ohio	MEDIC	AL DO
	gal Department		WILDIC	CAL BOARD
30	E. Broad St., 3'	Floor	AUG	1 9 2021

Columbus, OH 43215-6127



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	June	00	2021
Name of medical practice or factor Women's Med Dayton	Month cility at which RU-486 was pr	Day ovided:	Year
3. Address of medical practice or f 1401 E Stroop Rd	acility at which RU-486 was p	provided:	7,077
Dayton, Ohio 45429 4. Date post RU-486 complication	began: 8-2-2	02/	1 11
5. Event(s) Please check all that ap incomplete abortion Patient received a transfusion S Other serious event (specify)	Adverse reaction to RU-48	6Patient hospitali	zed
6. Duration of event:H	lours Days		
7. Remarks: incom ho fe	eflete pas tel hearth	sage of.	tissure
3. a. Name of physician who provid 3. b. Physician's signature	led RU-486 Jeann	e Corwin	/DO
30 E. E	State Medical Board of Ohi Department Broad St., 3 rd Floor abus, OH 43215-6127	MED	ICAL BOARD UG 1 9 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	6	3	2021
Name of medical practice or facility at Women's Med Dayton	Which RU-486 was provi	Day ded:	Year
3. Address of medical practice or facility a 1401 E Stroop Rd Dayton, Ohio 45429			
4. Date post RU-486 complication began:	8-3-202	21	-1141
5. Event(s) (Please check all that apply): Incomplete abortion A Patient received a transfusion Severe ble Other serious event (specify)	dverse reaction to RU-485 reding	Patient hospitali	zed
6. Duration of event: Hours	Days		
7. Remarks:			1100
3. a. Name of physician who provided RU-2	Date	e Roman	05 8/5/21
end completed forms to: State N Legal Departm 30 E. Broad St			CAL BOARD

Columbus, OH 43215-6127



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	8	2	2021
	Month	Day	Year
Name of medical practice or facility at Women's Med Dayton	which RU-486 was provi	ded:	
3. Address of medical practice or facility a 1401 E Stroop Rd	t which RU-486 was prov	vided:	
Dayton, Ohio 45429			
4. Date post RU-486 complication began:	8-10-20	21	
5. Event(s) (Please check all that apply):		10.	17-9-45
Incomplete abortion A	dverse reaction to RU-486	Patient hospitali	zed
Patient received a transfusion Severe ble	eding		
Other serious event (specify) Failed	MAB		
6. Duration of event: Hours	Days	10	
7. Remarks:		100	
111111111111111111111111111111111111111	29.04	and a second	
3. a. Name of physician who provided RU-	485 Deanne	Corwin	
3. b. Physician's signature	Date B	11/20x1	/D.O
end completed forms to: State I	Medical Board of Ohio		11
Legal Departr	ment	MED	ICAL BOARD
30 E. Broad St	t., 3 rd Floor	٨	is 1 9 2021

Columbus, OH 43215-6127



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	June	29 Day	2021
Name of medical practice or facility a Women's Med Dayton			Year
3. Address of medical practice or facility 1401 E Stroop Rd Dayton, Ohio 45429	at which RU-486 was p	rovided:	***
4. Date post RU-486 complication began	8-10-20	21	
Incomplete abortion Patient received a transfusion Severe b Other serious event (specify) 6. Duration of event: Hours		Patient hospit	alized
7. Remarks:	Days		
3. a. Name of physician who provided RL 3. b. Physician's signature	Cor	Corwing Corwin	
Legal Depart 30 E. Broad	e Medical Board of Ohio	MEDIC	CAL BOARD G 1 9 2021



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	6	24	21
	Month	Day	Year
2. Name of medical practice or facility Planned Parenthood	Λ	ded:	
3. Address of medical practice or facility 2314 Auburn Au			
4. Date post RU-486 complication bega 귀 3 カ 1 丑	n:		
5. Event(s) (Please check all that apply)	:		
Incomplete abortion	_ Adverse reaction to RU-486	Patient hospitalize	ď
Patient received a transfusion Severe	bleeding		
Other serious event (specify)			
6. Duration of event:3 Hours	Days		
7. Remarks:			
- 1			
. a. Name of physician who provided R	1)	berschan	1/
	Pyusas		
b. Physician's signature	/	7021	D.O
end completed forms to:	te Medical Board of Ohio		
Legal Depa	rtment		
30 E. Broad	d St., 3 rd Floor		
Columbus,	OH 43215-6127		



AUG 3 1 2021



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-485

1. Date RU-486 was provided:	July 9 2021
	fileonth O Day Year
2. Name of medical practice or facility at which	RU-486 was provided:
Women's Med Dayton	
Address of medical practice or facility at which 1401 E Stroop Rd	n RU-486 was provided:
Dayton, Ohio 45429	
4. Date post RU-486 complication began:	-19-2021
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: Hours	Days
7. Remarks: Dila ha	n: Suchica.
8. a. Name of physician who provided RU-486	Catherine Romanos MD
8. b. Physician's signature Da	te 8/19/20
Send completed forms to: State Medi	ical Board of Ohio
Legal Department	

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	Octobe	Y I Day	2021 Year
Name of medical practice or facility at v Women's Med Dayton	which RU-486 was provid	ed:	
3. Address of medical practice or facility at 1401 E Stroop Rd Dayton, Ohio 45429	which RU-486 was prov	ded:	- Walter and the control of the cont
4. Date post RU-486 complication began:	10/4/21	Bernande de la companya de la compa	en e
5. Event(s) (Please check all that apply):	The Manager Control of the Control o		
Incomplete abortionA	dverse reaction to RU-485	Patient hos	pitalized
Patient received a transfusion Severe ble	eeding		
Other serious event (specify)	culed me	die	aton
6. Duration of event: Hours	Days	energy the same of	
7. Remarks:	licated	DIC	
8. a. Name of physician who provided RU	1-486	RWIV	755555555555555555555555555555555555555
8. b. Physician's signature	Date 10	Spe	MD./DO
Send completed forms to: State	Medical Board of Ohio		
Legal Depart			MEDICAL BOARD
30 E. Broad S	St., 3 rd Floor		OCT 1 9 2021

Columbus, OH 43215-6127



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:		9	17		21
		Month	Day		Year
2. Name of medical practice or facili	ty at which Rl	J-486 was prov	ided:		
Women's Med Dayton					
3. Address of medical practice or faci 1401 E Stroop Rd	ility at which l	RU-486 was pro	ovided:		
Dayton, Ohio 45429					
4. Date post RU-486 complication be	gan:	(0/1/	21		
5. Event(s) (Please check all that app	ly);			A. 44-	The state of the s
X Incomplete abortion	Adverse re	eaction to RU-485	Patient hosp	italized	
Patient received a transfusion Sev	vere bleeding				
Other serious event (specify)					
6. Duration of event: Ho	ours	_ Days	A	999 h	177
7. Remarks: dílah	a : Sk	cha			
8. a. Name of physician who provide	ed RU-486	fat	herine	Kome	incs
8. b. Physician's signature	Date	10/	yai €	100	
Send completed forms to:	State Medic	al Board of Ohio	3		
Legal I	Department			MEDIC	CALBOARD
30 E. E	Broad St., 3 rd I	Floor		MEDIC	- + 0 2021
Colum	bus, OH 432	15-6127		00	T 1 9 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	7	20	21
	Month	Day	Year
2. Name of medical practice or facility at v	which RU-486 was provi	ded:	
Women's Med Dayton			
3. Address of medical practice or facility at 1401 E Stroop Rd	which RU-486 was pro-	vided:	
Dayton, Ohio 45429	1		
4. Date post RU-486 complication began:	9/83/3	21	And the second s
5. Event(s) (Please check all that apply):		A dispersion of the second of	900000000000000000000000000000000000000
Incomplete abortion A	dverse reaction to RU-485	Patient hospitali:	red
Patient received a transfusion Severe ble	eeding		
Other serious event (specify)	d map		Millionide Australia (Australia)
6. Duration of event: Hours _	Days	· · · · · · · · · · · · · · · · · · ·	
7. Remarks:	anders variables (AAA) materia, g. vo. propriation (1955 / AAA) keessa variables (AAAA)		
O - Name of shorten color was ideal Di	LAGE DOMA	ul Cor	win
8. a. Name of physician who provided RU	400		
8. b. Physician's signature		- 1 MD	// 00
	Date	2010	

Send completed forms to:

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Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

OCT 1 9 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	9	7	71
•	Month	Day	Year
Name of medical practice or facility at v	which RU-486 was pro	vided:	
Women's Med Dayton			
Address of medical practice or facility at 1401 E Stroop Rd	t which RU-486 was pr	ovided:	
Dayton, Ohio 45429			
4. Date post RU-486 complication began:	9/23/2	2(
5. Event(s) (Please check all that apply):			
Incomplete abortionA	dverse reaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion Severe ble	eeding		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:			
8. a. Name of physician who provided RU	1-486 Dea	une Coru	Mic
8. b. Physician's signature	Date 9	29/283	100
Send completed forms to: State	Medical Board of On	io	
Legal Depart			
30 E. Broad	St., 3 rd Floor		•

Columbus, OH 43215-6127



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

8	23	2021
Month	Day	Year
hich RU-486 was prov	ided:	
which RU-486 was pro	ovided:	A COLUMN TO THE PARTY OF THE PA
9-1-202	1	
and the state of t		9,0000000000000000000000000000000000000
dumme reaction to RII_486	Patient hasnit	alizaci
AAELDE LEBERROII ES LISTAGE	Westername I am should be to a subsequence of	M F 7 St. Tue No.
eding		
	The state of the s	A Company of the Comp
Days		
486 Keith-	le i singer	kindle DO
	N	W(00)-
9/2	1 12 1	
	which RU-486 was provided by the RU-486 was prov	which RU-486 was provided: 9-1-2021 diverse reaction to RU-486Patient hospit eding Days A86 Keith-Reisinger

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD 0CT 1 9 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	8	25	21
	Month	Day	Year
2. Name of medical practice or facility at which Planned Parenthood	RU-486 was pro	vided:	
3. Address of medical practice or facility at which	h RU-486 was pr	ovided:	
2314 Auburn Aus. a)	na, of	45219	
4. Date post RU-486 complication began: $9/3/n$			
5. Event(s) (Please check all that apply):			
Adverse	reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe bleeding			
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:			
`.			
8. a. Name of physician who provided RU-486	Dr.	Cowsinhay	
8. b. Physician's signature	ne e	uleiron	'D.O
Send completed forms to: State Medic	cal Board of Ohio)	
Legal Department			

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD 0CT 1 9 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	9	2	21
	Month	Day	Year
2. Name of medical practice or facility at which RI Planned Parenthood	J-486 was pro	vided:	
3. Address of medical practice or facility at which I	RU-486 was pr	ovided:	**************************************
2314 Auburn Aus. an	a, of	45219	
4. Date post RU-486 complication began: 9/9/3/			
5. Event(s) (Please check all that apply):			
Adverse real	action to RU-486	Patient hospitalized	ż
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		Dr Gon show	1
8. b. Physician's signature	uss (olalzoy M.D./	D.O
Send completed forms to: State Medical	Board of Ohio		
Legal Department			
30 E. Broad St., 3 rd Flo	or		

Columbus, OH 43215-6127

MEDICAL BOARD 0CT 1 9 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	August	13 Day	2021 Year
2. Name of medical practice or facility at w	vhich RU-486 was provided:		
3. Address of medical practice or facility at 12000 Shaker Blvd		d:	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Incomplete abortion Ad	lverse reaction to RU-486	Patient hospitali:	zed
Patient received a transfusion Severe blee			
6. Duration of event: 4 Hours			
7. Remarks:			
8. a. Name of physician who provided RU-4	486 Mitchell	1 Reider	, MD
8. b. Physician's signature	Date $ O \varphi$	21 M.D	_/D.O
Send completed forms to: State I	Medical Board of Ohio		
Legal Departr			
30 E. Broad Si Columbus, Ol	t., 3 rd Floor H 43215-6127		MEDICAL BOARD

OCT 2 0 2021

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



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	5	6	Y
	Month	Day	Year
2. Name of medical practice or facility at which F Planned Parenthood	RU-486 was pro	vided:	
3. Address of medical practice or facility at which	RU-486 was pr	ovíded:	
2314 Auburn Aus. ar	na, of	45219	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Incomplete abortion Adverse r	eaction to RU-486	Patient hospitalized	d
X Patient received a transfusion Y Severe bleeding			
Other serious event (specify)			
6. Duration of event: Hours 27	Days		
7. Remarks:			
`.			
8. a. Name of physician who provided RU-486	10	Dr. Kusy	
8. b. Physician's signature	rales	27/21 (MD)	D.O

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor Columbus, OH 43215-6127

MEDICAL BOARD SEP 2 8 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	8	17	N
·	Month	Day	Year
2. Name of medical practice or facility at which Planned Parenthood	RU-486 was prov	rided:	
3. Address of medical practice or facility at which	th RU-486 was pro	ovided:	
2314 Auburn Aus. a)	na, of	45219	
4. Date post RU-486 complication began: $8/23/27$			
5. Event(s) (Please check all that apply):	A A A A A A A A A A A A A A A A A A A		
Pincomplete abortion Adverse	reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe bleeding			
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:			
\.		,	
8. a. Name of physician who provided RU-486		Dr. Kalsy	
8. b. Physician's signature Da	laly te	(M.D)/0	2.0
Send completed forms to: State Medi	cal Board of Ohio	100000000000000000000000000000000000000	

Legal Department

30 E. Broad St., 3rd Floor Columbus, OH 43215-6127



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	neadde siedd moomong maestir.	27 NATURE 1 10 E O S E O O O O O O O O O O O O O O O O	21	
	Spires to Giboshowe not waihte	z wiscus divertibly Day	Year	
2. Name of medical practice or	facility at which RU-486 wa	s provided:		
Planned Parenthood	of Greater Ohio, provided	(Apartornia) (-A)		
	semieona viterani acente.	SSIGN 100 SSOUL I E.		
3. Address of medical practice of	r facility at which RU-486 w	as provided:		
3255 E. Main St. Columbus,	Oh 43213			
4. Date post RU-486 complication				
7/30/21				
5. Event(s) (Please check all tha	t apply):			
✓ Incomplete abortion	Adverse reaction to R	U-486Patient hos	spitalized	
	and the same			
Patient received a transfusion	Severe bleeding			
Other serious event (specify)				
6. Duration of event: 1	Hours Days			
7. Remarks: MAB procedure v	vas initiated per FDA regime	en on 7/27/21. Pt. ca	lled on 7/30/21 to rep	port
little to no bleeding. US on 8/3/2	21 revealed continuing preg	nancy. Surgical aspi	ration was performed	1 8/3/21;
pt. did well post op.	A standard of the second many and second many and second many and second second many and secon	PERMISSING STRUCK	84	
	natherality and a	And and Plantages		-
8. a. Name of physician who pro	vided RU-486 proportion RI	vlin occasional resources		-
8. b. Physician's signature	inother and the state of the st	entru con propin il	M.D. / D.O.	
	an liew an moled betail comp	5/27/21		
		1		

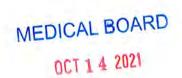
Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127





(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	7	14	2021
	Month	Day	Year
2. Name of medical practice or facility at v	which RU-486 was provide	ded:	
Planned Parenthood of Greater C	Ohio		
3. Address of medical practice or facility at	which RU-486 was prov	vided:	
25350 Rockside Rd. Bedford Hts., Oh 4	14146		
4. Date post RU-486 complication began:			
7/15/21			
5. Event(s) (Please check all that apply):			
X Incomplete abortion Ad	dverse reaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion Severe blee	eding		
Other serious event (specify)			
6. Duration of event: 1 Hours	Days		
7. Remarks: MAB procedure was initiate	ed per FDA regimen o	n 7/14/21, Pt. cal	led on 7/15/21 c/o little
to no bleeding in 24 hours. US on 7/16 was performed 7/16/21; pt. did well p	3/21 revealed continuir		
3. a. Name of physician who provided RU-	Dr. Vickery		
3. b. Physician's signature Uklaus	n Claver	M.B.	/D.O
	Date		

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	7	8	2021
	Month	Day	Year
Name of medical practice or facility at Planned Parenthood of Greater		ded:	
3. Address of medical practice or facility a	t which RU-486 was prov	vided:	
25350 Rockside Rd. Bedford Hts., Oh	44146		
4. Date post RU-486 complication began: 7/12/21			
5. Event(s) (Please check all that apply):			
X Incomplete abortionA	Adverse reaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion Severe ble	eeding		
Other serious event (specify)			
6. Duration of event: 1 Hours	Days		
7. Remarks: MAB procedure was initiat to no bleeding. US on 7/14/21 reveale called on 7/20/21 stating she had no brevealed continuing pregnancy. Pt. dec	d continuing pregnancy bleeding/cramping afte	y. 2nd dose of mi r 2nd dose of mis	soprostol given. Pt. so. US on 7/22/21
3. a. Name of physician who provided RU-	Dr. Vickery		
3. b. Physician's signature Colores	h O Kiwa	(M.D.	/ D.O
	Date	21	
Send completed forms to: State	Medical Board of Ohio		
Legal Departi	ment		

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

7	14	2021
Month	Day	Year
vhich RU-486 was provi	ded:	
hio		
which RU-486 was pro-	vided:	
4146		
lverse reaction to RU-486	Patient hospitalize	ed
eding		
Days		
d per FDA regimen o	n 7/14/21. Pt. call	ed on 7/15/21 c/o little
	ng pregnancy. Su	rgical aspiration
Dr. Vickery		
	8/26/202	<u> </u>
	which RU-486 was provided by the provided which RU-486 was provided which RU-486 was provided by the provided provided	Month Day which RU-486 was provided: Ohio which RU-486 was provided: 4146 Iverse reaction to RU-486 Patient hospitalize eding Days d per FDA regimen on 7/14/21. Pt. call /21 revealed continuing pregnancy. Su ost op. BB Dr. Vickery

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

	7	8	2021
	Month	Day	Year
Name of medical practice or facility at w Planned Parenthood of Greater Of		led:	
3. Address of medical practice or facility at		ided:	
25350 Rockside Rd. Bedford Hts., Oh 44	4146		
4. Date post RU-486 complication began: 7/12/21			
5. Event(s) (Please check all that apply):			
X Incomplete abortion Adv Patient received a transfusion Severe bleed Other serious event (specify)			ed
	6.77.6		
6. Duration of event: 1 Hours	Days		
7. Remarks: MAB procedure was initiated to no bleeding. US on 7/14/21 revealed called on 7/20/21 stating she had no bleevealed continuing pregnancy. Pt. decline in the continuing pregnancy.	d per FDA regimen or continuing pregnancy eeding/cramping after	 2nd dose of mi 2nd dose of mis 	soprostol given. Pt. o. US on 7/22/21

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD 0CT 1 4 2021

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		8	202.1	
	Month	Day	Year	
2. Name of medical practice or facility at	which RU-486 was provi	ded:		
Planned Parenthood Of G	reater Ohio			
	Marine de la constitución de la			THE STATE OF THE S
3. Address of medical practice or fac	ility at which RU-486	was provided:		
3255 E Main St, Columbus,	Ohio 43213			
4. Date post RU-486 complication be	egan: 7/19/21	No. of the state o	The thirty of applications on the control of	11-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1
5. Event(s) (Please check all that app	ly):	Property and the second secon	11 - 13 - 1411	West Control of the C
Incomplete abortion	Adverse reaction to RU-486	Patient baseitalise	d	
		Facient nospitalize	u	
Patient received a transfusion Severe b	leeding			
Other serious event (specify)		The state of the s	WHO CONTROL WITH COME SET THE CONTROL OF THE CONTRO	
6 Duration of quanta (Usana		197	C. Wirth Principle	15-SAMYROUGHER TO 1 THE SERVICE
6. Duration of event: Hours	Days		· Harrison · · · · · · · · · · · · · · · · · · ·	13 15 15 15 15 15 15 15 15 15 15 15 15 15
7. Remarks: MAR MOSCLA	11 20cs 0 m	ilicity of no	- / TD/\/\	201514 2 10 10 10
7/2/21 Fly 0011 res	1011 00 Carrie	ATIMECA JA	X FOT YU	egimen on
Jolos Allo Cord Lov	Film Lianis	moed you	gruincy SI	٥.
7. Remarks: MAB proced 1/2/21. Flu call rev Surgical aspira	TIDIA NOVO	Sino	ZI V	**************************************
8. a. Name of physician who provided	1 KU 486	ornay		
8. b. Physician's signature			_ M.D.D.O	
	Date 1	21/21		
end completed forms to:	State Medical	Board of Ohio	And the state of t	TALIST
÷ .	egal Department			
	00 E. Broad St., 3rd Floo			
3	o L. Diodu St., 3" Floo	JI.		

Columbus, OH 43215-6127

MEDICAL BOARD 0CT 1 4 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	10 Q 3
2. Name of medical practice or facility	at which RU-486 was provided:
Women's Med Dayton	
3. Address of medical practice or facility 1401 E Stroop Rd	ty at which RU-486 was provided:
Dayton, Ohio 45429	
4. Date post RU-486 complication beg	an: 10/12/21
5. Event(s) (Please check all that apply);
X Incomplete abortion	Adverse reaction to RU-485 Patient hospitalized
Patient received a transfusion Sever	re bleeding
Other serious event (specify)	
6. Duration of event: Hou	rs Days
7. Remarks:	
8. a. Name of physician who provided	RU-186 Jeanne Corwin
8. b. Physician's signature	Date 10/12/21
Send completed forms to:	State Medical Board of Ohio
	epartment
30 E. Br	oad St., 3 rd Floor

Columbus, OH 43215-6127

OCT 2 7 2021
STATE MEDICAL BOARD OF OHIO

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided: One 23
2. Name of medical practice or facility at which RU-486 was provided:
capital cape of Tollab, Oh LLC
Address of medical practice or facility at which RU-486 was provided:
1160 W Sylvania Ave Toledo, Oh 43606
4. Date post RU-486 complication began: 6 123/2
5. Event(s) (Please check all that apply):
Incomplete abortionAdverse reaction to RU-486 Patient hospitalized
Patient received a transfusionSevere bleeding
Vother serious event (specify) missed Hailed
6. Duration of event: Hours Days
7. Remarks: Ongoing Viable pregnancy after medication absorbed
8. a. Name of physician who provided RU-486. 8. b. Physician's signature Date Date
Send completed forms to: State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	05	20	21	
Name of medical practice or facility at which	Month n RU-486 was provided:	Day	Year	
Carital care of	Tolda, oh	ble		
3. Address of medical practice or facility	at which RU-486 was	provided:		
				,
4. Date post RU-486 complication began	512012	T		
5. Event(s) (Please check all that apply):				
Incomplete abortionAdver	se reaction to RU-486	Patient hospitalized		
Patient received a transfusionSevere bleedi	ailed Mla	tical		
6. Duration of event: Hours 13	Days			
7. Remarks:		***	,	
8. a. Name of physician who provided R	4-486 DV	Britta	ny	
8. b. Physician's signature	Date_	\sim	M.D/0.0)_	· · · · · · · · · · · · · · · · · · ·
Send completed forms to:	State Medical Bo	ard of Ohio		
Leg	al Department			
30 8	. Broad St., 3rd Floor			

Columbus, OH 43215-6127

NOV 02 2021



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provid	ed:	11/ 1-	1/21		
		Month	1	Day	Year
2. Name of medical practic Planned Pare	^	ch RU-486 was pro	vided:		
3. Address of medical pract	ice or facility at wh	nich RU-486 was p	ovided:		
2314 Auburr	· Au. C	ina, of	452	19	
4. Date post RU-486 compli	7/21				
5. Event(s) (Please check all	that apply):				
	Adver	se reaction to RU-486	Patien	t hospitalized	
Patient received a transfusio	n Severe bleedin	g			
Other serious event (specify)					
6. Duration of event:	3Hours	Days			
7. Remarks:				7.77.1	
					_
	\				
8. a. Name of physician who	provided RII-486		Dr. K	6/50	
8. b. Physician's signature	1	ra les		(NO)	^
o. D. PHYSICIAN S SIGNATURE	D	Date ///	2/22	(W.D)/D	
Send completed forms to:	State Me	dical Board of Ohi)		
	Legal Departmen	nt			
	30 E. Broad St., 3	rd Floor			
	Columbus, OH 4	3215-6127			a magnetic of the p



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:		12	9	2021
		Month	Day	Year
2. Name of medical practice or faci	lity at which RU-	486 was prov	ided:	
Planned Parenthood of Greate	er Ohio			
3. Address of medical practice or fa	cility at which RU	J-486 was pro	vided:	
25350 Rockside Rd. Bedford F	Hts. Ohio 44	146		
4. Date post RU-486 complication b		ALL SOLES		
12/14/21	-0			
5. Event(s) (Please check all that ap	ply):			
x				
X Incomplete abortion	Adverse reac	tion to RU-486	Patient hospitalized	1
Patient received a transfusion Se	vere bleeding			
	vere biccamp			
Other serious event (specify)				
Other serious event (specify)				
C Duration of success 1	F			
6. Duration of event: 1 He	oursL	Days		
7. Remarks: MAB procedure was in	nitiated per FDA	regimen on 12	2/9/21. F/U call on 12	/14/21 revealed pt. had
an US at her OB office that revealed				
Pt. did well post op.				
8. a. Name of physician who provide	ed RU-486	Dr. Vickery		
8. b. Physician's signature		17	M.D./	D.O
	Date —			
Send completed forms to:	State Medical B	Board of Ohio		-2
Legal [Department			
	Broad St., 3 rd Floo	or		
	hus OH 43215-			



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	10	12	2021
	Month	Day	Year
2. Name of medical practice or facility at which	RU-486 was provid	ded:	
Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which	th RU-486 was prov	vided:	
25350 Rockside Rd. Bedford Hts. Ohio	44146	100	
4. Date post RU-486 complication began:			
11/18/21			
5. Event(s) (Please check all that apply):			
X Incomplete abortion Adverse	reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Severe bleeding			
Other serious event (specify)			
6. Duration of event: 1 Hours	Days		
7. Remarks: MAB procedure was initiated per I	FDA regimen on 10	0/12/21. FU US on	11/18/21 revealed
Continuing pregnancy. Pt. preferred to continue			
asap.			
8. a. Name of physician who provided RU-486	Dr. Brant		
8. b. Physician's signature	12UV	M.D.	/ D.O
Da	te 12-21-	2	

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	10	21	2021	
2. Name of medical practice or facility	Month / at which RU-486 was pro	Day	Aeal	
Planned Parenthood Of	,	,		
Address of medical practice or	facility at which RU-48	6 was provided:		
3255 E Main St, Columb	us, Ohio 43213			
4. Date post RU-486 complication	n began: 1 23 20 2			
5. Event(s) (Please check all that	apply):			
Incomplete abortion .	Adverse reaction to RU-486	6 Patient hospital	ized	
Patient received a transfusionSev	ere bleeding			
Other serious event (specify)	truuterine	. clebn5		
6. Duration of event: Hou	rs Days			
7. Remarks: Patient C. for several weeks debns:	alled on-cal post MAB. 1	11 8 Night	ytell bleeding pu showed	intrautenne
8. a. Name of physician who prov	rided RU-486 DY	, Sinay		
8. b. Physician's signature	On	12-2-	0.0	
	Date	11.0	WU	
Send completed forms to:	State Medic	cal Board of Ohio		
	Legal Department			
	30 E. Broad St., 3rd I	Floor		

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	6	28	21
	Month	Day	Year
2. Name of medical practice or facility at which	RU-486 was prov	ided:	
Planned Parenthood of Greater Ohio			· · · · · · · · · · · · · · · · · · ·
3. Address of medical practice or facility at whic	h RU-486 was pro	ovided:	
3255 E. Main St. Columbus, Oh 43213			
4. Date post RU-486 complication began:			
8/6/21			
5. Event(s) (Please check all that apply):			
✓ Incomplete abortion Adverse	reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe bleeding			
Other serious event (specify)			
6. Duration of event: 1 Hours	Days		
7. Remarks: MAB procedure was initiated per FD and bleeding/cramping. Pt. went to ER on 8/5/21 incomplete AB. Pt. did well post op and will follo	1 and had suction	procedure after ultra	
8. a. Name of physician who provided RU-486 8. b. Physician's signature Date	Dr. McClune 1 2/6/	(M.D.)	<u>do</u>

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

. Date RU-486 was provided:	Dec	. 21	2021	
	Month	Day	Year	
. Name of medical practice or facility a				
Your anone k	erblace Ll	C	`	
. Address of medical practice or fa	cility at which RII-486	5 was provided:		
6721 Karl Rd			29.	
Date post RU-486 complication b				
. Event(s) (Please check all that ap			*	()
, failed	"Adverse reaction to RU-486	Patient höspitalit	red	
Patient received a transfusion Seven	bleeding			
Other serious event (specify)		4		
. Duration of event: Hours	O Days			
remarks: Falch MAB	. Mediaku	separed	c succes.	
3. a. Name of physician who provid	ed RU-486	wicion n	DONNE 10	
3. b. Physician's signature	Date	1.12.2022		
nd completed forms to:	State Medic	al Board of Ohio		
	Legal Department			
	30 E. Broad St., 3rd F	loor		

Columbus, OH 43215-6127

JAN 2 4 2022



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:		8	25	n
		Month	Day	Year
2. Name of medical practice or fa Planned Parenth	1	486 was provi	ded:	
3. Address of medical practice or f				
4. Date post RU-486 complication $9/3/m$	began:	,		
5. Event(s) (Please check all that a	pply):			
Incomplete abortion	Adverse react	ion to RU-486	Patient hospitalize	ed .
Patient received a transfusion S	Severe bleeding			
Other serious event (specify)				
5. Duration of event:	lours D	eys		
7. Remarks:				
4				
3. a. Name of physician who provid	led RU-486	Dr. 6	wishay	
3. b. Physician's signature	pyrisa		M.D./	D.O
	Date —	01	16/1001	
end completed forms to:	State Medical Bo	ard of Ohio		
Legal	Department			
	Broad St., 3 rd Floor		JA	N 13 2022
Colum	bus, OH 43215-63	127	OTABE MED	CAL DOADS OF OUR



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	11	10	21
	Month	Day	Year
2. Name of medical practice or facility at Planned Parenthood	which RU-486 was provid	ded:	
3. Address of medical practice or facility a 2314 Auburn Au.			
4. Date post RU-486 complication began: $121/24$		· · · · · · · · · · · · · · · · · · ·	**************************************
5. Event(s) (Please check all that apply):	dverse reaction to RU-486 .eding	Patient hospitalized	
6. Duration of event:l Hours	Days		
7. Remarks:			110
a. Name of physician who provided RU-	486 <u>Dr.</u>	line	
. b. Physician's signature	Date 1/5/	M W.D/1	2.0
	Medical Board of Ohio		1-10-1
Legal Departm	ant		

Columbus, OH 43215-6127

JAN 13 2022

STATE MEDICAL BOARD OF ONE



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	_/0	6	21
201	Month	Day	Year
2. Name of medical practice or facility Planned Parenthood		ded:	
3. Address of medical practice or facility 2314 Auburn Au			
4. Date post RU-486 complication bega	The state of the s	732.1	
5. Event(s) (Please check all that apply)	:	W ₁ .	
Incomplete abortion	_ Adverse reaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion Severe	bleeding		
Other serious event (specify)			
6. Duration of event: 2 Hours	Days		
7. Remarks:			
18			
. a. Name of physician who provided R	U-486	bur sahan	
. b. Physician's signature	Date 1/5/20	M.D./	D.O
	e Medical Board of Ohio		
Legal Depar			
30 F Broad	St 3rd Floor		

Columbus, OH 43215-6127

JAN 13 2022



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	10	11	21
141-	Month	Day	Year
Name of medical practice or facility at v Women's Med Dayton	which RU-486 was provid	ed:	
3. Address of medical practice or facility at 1401 E Stroop Rd	which RU-486 was prov	deď:	192
Dayton, Ohio 45429			
4. Date post RU-486 complication began:	10/15/2	1	
5. Event(s) (Please check all that apply):			*****
Incomplete abortion Ac	dverse reaction to RU-486	Patient hospitaliz	ted
Patient received a transfusion Severe blee	eding		
Lether serious event (specify)			
5. Duration of event: Hours	Days		
7. Remarks:			
		- A	- 6.3
3. a. Name of physician who provided RU-2	486 Deanne	- Corr	UIY
B. b. Physician's signature	Date	MD	/00
and completed forms to	L M. Pyr		

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

NOV 16 2021

STATE MEDICAL BOARD OF CHIO



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	10	26	21
	Month	Day	Year
Name of medical practice or facility at Women's Med Dayton	which RU-486 was pro-	vided:	
3. Address of medical practice or facility a 1401 E Stroop Rd	t which RU-486 was pro	ovided:	
Dayton, Ohio 45429			
4. Date post RU-486 complication began:	11/1/20	21	
5. Event(s) (Please check all that apply):		1920	
V	Adverse reaction to RU-485	Patient hospitali	ze d
Patient received a transfusion Severe ble	eeding		
Other serious event (specify)	78		
6. Duration of event: Hours _	Days		
7. Remarks:		***	
a. Name of physician who provided RU-	486 Kliff.	Keisinger-	Kindle
I. b. Physician's signature	2/2	8/21 MD	60
	Medical Board of Ohio		
Legal Departr			
30 E. Broad St	t., 3 rd Floor		

Columbus, OH 43215-6127

NOV 16 2029



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	10	14	21
	Month	Day	Year
2. Name of medical practice or facility a Planned Parenthood		ded:	
3. Address of medical practice or facility 2314 Auburn Am.			
4. Date post RU-486 complication began):		***
5. Event(s) (Please check all that apply):			1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -
	_Adverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe b	bleeding		
Other serious event (specify)			
6. Duration of event: 2 Hours	Days		
7. Remarks:		1774-1101	
į į.			
B. a. Name of physician who provided RU	J-486	Dr. talsy	
B. b. Physician's signature	Milla	7 MD/I	2.0
	Date 11/23/	21	
end completed forms to: State	e Medical Board of Ohio		illee — ir
Legal Depar	tment		
30 E. Broad	St., 3 rd Floor		
Columbus, C	DH 43215-6127		



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	10	13	21
2000	Month	Day	Year
2. Name of medical practice or facility Planned Parenthood		vided:	
3. Address of medical practice or facility	y at which RU-486 was pr	ovided:	
2314 Auburn Au			
4. Date post RU-486 complication began			100
5. Event(s) (Please check all that apply):		***	
Incomplete abortion	_Adverse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusionSevere	bleeding		
Other serious event (specify)			
6. Duration of event: 2 Hours	Days		
7. Remarks:	-	3928444	
B. a. Name of physician who provided RI	J-486	Kalsy	
B. b. Physician's signature	Mad	as MD1	D.O
	Date//	191/21	
end completed forms to: State	e Medical Board of Ohio		
Legal Depar			
	St., 3 rd Floor		
	St., 3 Floor OH 43215-6127		



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	10	8	H
	Month	Day	Year
2. Name of medical practice or facility a Planned Parenthood		ided:	
3. Address of medical practice or facility 2314 Auburn Au.			
4. Date post RU-486 complication began	:		
5. Event(s) (Please check all that apply):			
Lincomplete abortion	Adverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe b	leeding		
Other serious event (specify)	All stan		
5. Duration of event: Hours	Days		
7. Remarks:			
. a. Name of physician who provided RL	J-486	linsel	064
b. Physician's signature		1, d.M	
	Date 12/3/74		
end completed forms to: State	Medical Board of Ohio	1 1000	
Legal Depart	ment		
30 E. Broad	St., 3 rd Floor		
Columbus, C	H 43215-6127		



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:		17	2/
	Month	Day	Year
2. Name of medical practice or faci Planned Parentho		ded:	
3. Address of medical practice or face 2314 Auburn Au			
4. Date post RU-486 complication by $11/19/21$	egan:		
5. Event(s) (Please check all that app	oly):		
	Adverse reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Sev			
6. Duration of event: 2 Ho	ours Days		
7. Remarks:		11004	
· .			
3. a. Name of physician who provide	d RU-486	. Kalsy	
B. b. Physician's signature	Mades	MD/	0.0
	Date	3/21	
end completed forms to:	State Medical Board of Ohio		
	epartment		
30 E. Br	oad St., 3 rd Floor		
Columb	us, OH 43215-6127		



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	_/0	15	2/
226	Month	Day	Year
2. Name of medical practice or facility Planned Parenthood		ded:	
3. Address of medical practice or facilit	y at which RU-486 was prov	vided:	
2314 Auburn Au			
4. Date post RU-486 complication bega ノン/ンナ	n:	37	
5. Event(s) (Please check all that apply)			
Incomplete abortion	_ Adverse reaction to RU-486	Patient hospitalized	d) i
Patient received a transfusion Severe	bleeding		
Other serious event (specify)			
6. Duration of event: 2 Hours	Days		01
7. Remarks:	30 /	STORES Special	
a. Name of physician who provided R		0	1112
To home of physician who provided to	U-486	Flock	
	U-486		0.0
b. Physician's signature	U-486	12/3/2/	D.O
. b. Physician's signature	9	Cub.	0.0
. b. Physician's signature	Date	Cub.	0.0

Columbus, OH 43215-6127

DEC 0 9 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	10	27	7/
	Month	Day	Year
2. Name of medical practice or facility a Planned Parenthood		vided:	
3. Address of medical practice or facility 2314 Auburn Aw.			-
4. Date post RU-486 complication began $/\delta/24/21$:		***************************************
5. Event(s) (Please check all that apply):			
Incomplete abortion	Adverse reaction to RU-486	Patient hospitalized	d
Patient received a transfusion Devere b	leeding		
Other serious event (specify)			
6. Duration of event: 3 Hours	Days		11.4
7. Remarks:		Night Hard Control of the Control of	
*			111
3. a. Name of physician who provided RU	1-486 De Pu	nsah	
B. b. Physician's signature		MB/	0.0
	Date —	1213121	
end completed forms to: State	Medical Board of Ohio		
Legal Depart	ment		
30 E. Broad S	St., 3 rd Floor		

Columbus, OH 43215-6127

DEC 0.9 2021 STATE MEDICAL BOARD OF OHIO



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:		19	21
7.754	Month	Day	Year
Name of medical practice or facility at Women's Med Dayton	which RU-486 was pro	ovided:	
3. Address of medical practice or facility a 1401 E Stroop Rd Dayton, Ohio 45429	it which RU-486 was p	rovided:	
4. Date post RU-486 complication began:	11/24/2	21	
5. Event(s) (Please check all that apply):			
Incomplete abortion A	Adverse reaction to RU-488	Patient hospitaliz	ed
Patient received a transfusion Severe bis	eeding		
X Other serious event (specify) Failed	Abortion		
6. Duration of event: Hours _	Days		
7. Remarks:	97.1	,	
3. a. Name of physician who provided RO	-285 Pay	therine t	Lomanos
B. b. Physician's signature	100)
	Date #	12/3/2/MD	10.0
end completed forms to: State	Medical Board of Ohio	>	(
Legal Departs	mant		

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

DEC 15 2021

STATE MEDICAL BOARD OF OHIO



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	Month	03	2021
Name of medical practice or facility at Women's Med Dayton		vided:	Year
3. Address of medical practice or facility a	at which RU-486 was pro	ov ded:	
Dayton, Ohio 45429			
4. Date post RU-486 complication began:	11/20/21		
5. Event(s) (Please check all that apply):	11/00/1/01		7 b
Incomplete abortion	Adverse reaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion Severe bi	eeding		
Other serious event (specify)	led abo	rtion	
6. Duration of event: Hours _	Days	***	
7. Remarks: WMCeV	nslicente	J. D4 (7
3. a. Name of physician who provided Ry- 3. b. Physician's signature	486 Jeanne)p.o.
end completed forms to: State	Date		, , , , , , , , , , , , , , , , , , , ,
Legal Departr	Medical Board of Ohio		

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

DEC 1 5 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	10	5	21
	Month	Day	Year
2. Name of medical practice or facility at w Planned Parent hood		ded:	
3. Address of medical practice or facility at			119
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):		11	***
Adv	verse reaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion Severe blee	ding		
Other serious event (specify)			
6. Duration of event:2_ Hours	Days		
7. Remarks:		Te min	
3. a. Name of physician who provided RU-4	86 D.	Kalsy	
3. b. Physician's signature	Maly	(M.D)	/ D.O
	Date		
	Medical Board of Ohio		
Legal Departme	ent		

Columbus, OH 43215-6127

NOV 09 2021

State Medical Board of Ohio

Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486
STATE MEDICAL BOARD OF OHIO

Date RU-486 was provided:	9	7	2021	
1 11 11 11 11 11 11 11 11	Month	Day	Year	
2. Name of medical practice or facility at whi			110000	
3. Address of medical practice or facility (272) Karl Re		was provided: 10h 432 2021	L29	
4. Date post RU-486 complication began	9/22/	2021		
5. Event(s) (Please check all that apply): Incomplete abortionAdv. Patient received a transfusionSevere bleed Other serious event (specify)	erse reaction to RU-486	Patlent hospitalize	d	
6. Duration of event; Hours	Days			The second section of the second seco
7. Remarks: Reffered for	SAB			
8. a. Name of physician who provided R 8. b. Physician's signature	Date 11	lam Lo SyMD 116/2021	douck. (M.D/D.O_	

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	12	28	21
	Month	Day	Year
2. Name of medical practice or facility at which R Planned Parenthood	U-486 was prov	vided:	
3. Address of medical practice or facility at which	RU-486 was pro	ovided:	
2314 Auburn Aue. Cin	a, of	45219	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Incomplete abortionAdverse re	eaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Severe bleeding Other serious event (specify)			
6. Duration of event: Hours	_ Days		
7. Remarks:			
B. a. Name of physician who provided RU-486		Dr. Kg/84	7

Legal Department

30 E. Broad St., 3rd Floor



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided	:	12	29	2/
		Month	Day	Year
2. Name of medical practice. Planned Parev	1	ch RU-486 was prov	ided:	
3. Address of medical practice	or facility at wi	nich RU-486 was pro	vided:	
2314 Auburn	Au. C	ina, of	45219	
4. Date post RU-486 complica				
5. Event(s) (Please check all the	nat apply):			
Incomplete abortion	Adve	rse reaction to RU-486	Patient hospitalize	:d
Patient received a transfusion	Severe bleedir	ng		
Other serious event (specify) _				
6. Duration of event:	Hours	2 Days		
7. Remarks:			,	
Α.				
8. a. Name of physician who p	provided RU-486	5	Dr. K61	Sy
8. b. Physician's signature	4000	Mals	M	/D.O.
,	1	Date7/8	In	
Send completed forms to:	State Me	dical Board of Ohio		
	Legal Departme	nt		
:	30 E. Broad St., 3	3 rd Floor		
	Columbus, OH 4	13215-6127		



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	17	18	21
	Month	Day	Year
2. Name of medical practice or facility a Planned Parenthood		rovided:	
3. Address of medical practice or facility	at which RU-486 was j	provided:	
2314 Auburn Aue.	ana, ot	1 45219	
4. Date post RU-486 complication began	i:		
5. Event(s) (Please check all that apply):			
Incomplete abortion	_Adverse reaction to RU-48	86 Patient hospitaliz	ed
Patient received a transfusion Severe l	bleeding		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:			
٧.			
3. a. Name of physician who provided R	U-486	Dr. L'm	
3. b. Physician's signature	<i>X</i>		/D.O
	Date/	128/14	
Send completed forms to: Stat	te Medical Board of Oh	nio	
Legal Depa			
30 E. Broad	l St., 3 rd Floor		

Columbus, OH 43215-6127

FEB 17 2022



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	october	22	2021
	Month	Day	Year
2. Name of medical practice or facility a	t which RU-486 was provided	Preter	m
3. Address of medical practice or facility	at which RU-486 was provide	clevelor	Shaher Blvd d, OH 44120
4. Date post RU-486 complication began	10/27/21		
5. Event(s) (Please check all that apply):			
X Incomplete abortion	Adverse reaction to RU-486	Patient hospitaliz	red
Patient received a transfusion Severe b	pleeding		e e e
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:			
	•		
8. a. Name of physician who provided RI 8. b. Physician's signature	Mitchell Date 2/75 22	1	₩ Ô / D.O
Send completed forms to: Stat	e Medical Board of Ohio		
Legal Depa	*	,	
30 E. Broad	St., 3 rd Floor		
	OH 43215-6127		



(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	Q 2	2021 Year	
2. Name of medical practice or facility at which	RU-486 was provided:	Preterm		
3. Address of medical practice or facility at whic	h RU-486 was provided:	12000 Sho		
4. Date post RU-486 complication began:	112/21			
5. Event(s) (Please check all that apply): Incomplete abortion Adverse Patient received a transfusion Severe bleeding Other serious event (specify) 6. Duration of event: Hours		ient hospitalized		
7. Remarks:				
8. a. Name of physician who provided RU-486 8. b. Physician's signature Dat	minam C un Or se 319	rener, M 	.D	
Send completed forms to: State Medic Legal Department 30 E. Broad St., 3 rd	cal Board of Ohio			



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	12	23	21
	Month	Day	Year
Name of medical practice or facility at Women's Med Dayton	which RU-486 was pro-	vided:	
3. Address of medical practice or facility a 1401 E Stroop Rd Dayton, Ohio 45429	et which RU-486 was pr	ovided:	1 2
4. Date post RU-486 complication began:	6/83		
5. Event(s) (Please check all that apply):		5 L	-
Incomplete abortion	Adverse reaction to RU-486	Patient hospitali	ted
Patient received a transfusion Severe ble	eeding		
Other serious event (specify)			
6. Duration of event: Hours _	Days		
7. Remarks:	i (1)		
uncap	brated Su	etics.	
3. a. Name of physician who provided RU 3. b. Physician's signature	Date Catherin	s homanos	122
	LA SELEC		100-

Legal Department

30 E. Broad St., 3"d Floor

Columbus, OH 43215-6127

STATE MEDICAL BOARD OF OHIO



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

	vided:	December	3	2021
		Month	Day	Year
Name of medical prac Women's Med Da		ch RU-486 was provided:	· ·	
3. Address of medical pra 1401 E Stroop Rd Dayton, Ohio 4542		hich RU-486 was provided	J;	i i i i i i i i i i i i i i i i i i i
4. Date post RU-486 com	plication began:	19/16/21	111	·, · · · ·
5. Event(s) (Please check : Incomplete abortion Patient received a transfus	Adve	rse reaction to RU-486 P	atient hospitalize	ď
Other serious event (speci	91	- W		
Duration of ovent.	Hours	Days		
6. Duration of event: 7. Remarks:	emplicated	suction		
7. Remarks:	emplicated no provided RU-486		Roman	
7. Remarks:	no provided RU-486		Comunica Com	200

FEB 1 1 2022 STATE MEDICAL BOARD OF OHIO



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided	:	11	24	2001
		Month	Day	Year
Name of medical practice of Women's Med Dayton	or facility at which R	U-486 was prov	vided:	
3. Address of medical practice 1401 E Stroop Rd	or facility at which	RU-486 was pro	ovided:	And the state of t
Dayton, Ohio 45429		()74444		
4. Date post RU-486 complication	tion began:			-
5. Event(s) (Please check all th	at apply):	· · · · · · · · · · · · · · · · · · ·		
Incomplete abortion	Adverse re	action to RU-485	Patient hospita	alized
Patient received a transfusion Other serious event (specify)	_Severe bleeding	ed a	borte	
6. Duration of event:	Hours	Days		
7. Remarks:	ated	e De	EC	
B. a. Name of physician who pr B. b. Physician's signature	ovided RV-486	Jeann	e Convi	D, MD
	Date .	1/4/	93_	D, D.O
end completed forms to;	State Medical	Board of Ohio		3.500
Le	gal Department			
30	E. Broad St., 3'd Flo	or		A // 0000
	olumbus, OH 43215		STAT	FEB 1 1 2022 TE MEDICAL BOARD OF OWNE



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

Month ch RU-486 was prov lich RU-486 was pro	(AA4)	Year
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ich RU-486 was pro	o viel a di	
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se reaction to RU-486	Patient hospitaliz	ed
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Days		White Lambard Market
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	Catherine	Remanos
	16	Dog
	> 1/4/27	
	110102	
	SH / QQ se reaction to RU-486 B Days	Se reaction to RU-485 Patient hospitalize B Days Catherina AG I/S/22 Sical Board of Ohio

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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

FEB 1 1 2022

STATE MEDICAL BOARD OF OHIO



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	12	2	21
	Month	Day	Year
2. Name of medical practice or facility at which	ch RU-486 was provi	ded:	
Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at wh	nich RU-486 was prov	vided:	
25350 Rockside Rd. Bedford Hts. Oh	nio 44146		
4. Date post RU-486 complication began:			
1/14/22			
5. Event(s) (Please check all that apply):			
V Jaconsulata abantian	tion to DU 486	Dationa ha anisalia	
X Incomplete abortion Adver	rse reaction to RU-486	Patient nospitaliza	ea
Patient received a transfusion Severe bleeding	ng		
Other serious event (specify)			
C. Duration of quart. 1	Davis		
6. Duration of event: 1 Hours	Days		
7. Remarks: MAB procedure was initiated per	FDA regimen on 12/2	2/21. Pt. called on	1/14/22 with c/o +HSP7
US performed on 1/20/22 revealed continuing	-		
pt. did well post op.			
8. a. Name of physician who provided RU-486	Dr Vickery		
8. b. Physician's signature	Mb	M.D.	/ D.O
	Date		
	dical Board of Ohio		-

Legal Department

30 E. Broad St., 3rd Floor