Rept #6

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: January (Month) 12 (Day) 2012 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Central Ohio Women's Center

3. Address of medical practice or facility at which RU-486 was provided:
3255 East Main St Columbus, OH 43213

4. Date post RU-486 event began: 2/10/12

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) moderate bleeding

6. Duration of event: 2 Hours _____ Days

7. Remarks: D and C done for moderately heavy bleeding at time of routine follow up.

8. a. Name of physician who provided RU-486 Keder

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

Date 5/7/12.

Send completed forms to:

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

MEDICAL BOARD
MAY 21 2012

2012 MAY 21 AM 8:04
STATE MEDICAL BOARD OF OHIO

Prescribed: 5/--/2011

Rpt #8

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: 01 (Month) 19 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
19550 ROCKSIDE RD. BEDI

4. Date post RU-486 event began:
2/17/12

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: 1 Hours 8 Days

7. Remarks:
Pt never returned for F/U so don't know if completed on her own

8. a. Name of physician who provided RU-486 DR. DAVID BURKONS

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

Date 5/16/12

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

2012 MAY 29 PM 2:15
STATE MEDICAL BOARD OF OHIO

MEDICAL BOARD
MAY 29 2012

Prescribed: 5/--/2011

Report #12

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: 3 (Month) 6 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd Bedford Hts OH 44146

4. Date post RU-486 event began:
3/20/12

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: 1 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Sarah K Smith MD

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

Date 3/27/12

Send completed forms to:

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

MEDICAL BOARD
APR - 2 201

Prescribed: 5/--/2011

Report #23

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: 3 (Month) 7 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd Bedford Hts OH 44146

4. Date post RU-486 event began:
3/20/12

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: ___1___ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 David Burnons MD

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

Date 3/26/12

Send completed forms to:

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



Prescribed: 5/--/2011

Report #26

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: 3 (Month) 13 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd
Bedford Hts OH 44146

4. Date post RU-486 event began:
4/5/12

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: ___1___ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Sarah K Smith MD

8. b. Physician's signature _____ M.D. / D.O
Date 5/1/12

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

MEDICAL BOARD
MAY 04 2012

Prescribed: 5/--/2011

Rept#7

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: March (Month) 19 (Day) 2012 (Year)

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

Central Ohio Women's Center

3. Address of medical practice or facility at which RU-486 was provided:

3255 East Main St Columbus, OH

4. Date post RU-486 event began:

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

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

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Catherine Conrad

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

Date 5/14/12

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

MEDICAL BOARD
MAY 24 2012

Prescribed: 5/--/2011

Report #24

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: 3 (Month) 27 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd
Bedford Hts OH 44146

4. Date post RU-486 event began: 4/14/12

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: 1 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Sarah K Smith MD

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

Date 4/24/12

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

MEDICAL BOARD
MAY 04 2012

Prescribed: 5/--/2011

Report #25

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: 3 (Month) 28 (Day) 12 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd Bedford Hts OH 44146

4. Date post RU-486 event began:
4/13/12

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: 1 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 David M Burmans MD

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

Date 4/19/12

Send completed forms to:

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

MEDICAL BOARD
MAY 04 2012

Prescribed: 5/--/2011

Rept # 12

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: 4 (Month) 4 (Day) 2012 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Central Ohio Women's Center

3. Address of medical practice or facility at which RU-486 was provided:
3155 E. Main Street Columbus Ohio 43213

4. Date post RU-486 event began: 4-12-12

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

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

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: _____ Hours 14 Days

7. Remarks:

8. a. Name of physician who provided RU-486 _____

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

Date 5/30/12

Send completed forms to:

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

MEDICAL BOARD
MAY 31 2012

Prescribed: 5/--/2011

Rpt 17

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: 5 (Month) 8 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd Bedford Hts OH 44146

4. Date post RU-486 event began:
6/15/12

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: ___1___ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 David Burkons MD

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

MEDICAL BOARD
JUN 28 2012

Prescribed: 5/--/2011

Rpt# 15

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: 05 (Month) / 16 (Day) / 2012 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
CENTRAL OHIO WOMEN'S CENTER

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. MAIN STREET Columbus, OHIO 43213

4. Date post RU-486 event began:
04-04-12

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:

8. a. Name of physician who provided RU-486 Catherine Cardno, MD

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

Date 6/11/12

Send completed forms to:

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



Prescribed: 5/--/2011

rept # 13

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: 05 (Month) 17 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 ROCKSIDE RD
BEDFORD HEIGHTS, OH 44146

4. Date post RU-486 event began:
6-6-12

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: 1 Hours 0 Days

7. Remarks:

MEDICAL BOARD
JUN 13 2012

8. a. Name of physician who provided RU-486 DAVID BUNKENS, MD

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

Date 6/6/12

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

Prescribed: 5/--/2011

rept #14

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: 5 (Month) 29 (Day) 12 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 ROCKSIDE RD
BEDFORD HTS, OH 44146

4. Date post RU-486 event began:
6-7-12

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: 1 Hours Ø Days

7. Remarks:

8. a. Name of physician who provided RU-486 DR. DAVID BURKONS

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

Date 6/8/12

Send completed forms to:

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

MEDICAL BOARD
JUN 13 2012

Prescribed: 5/--/2011

Rpt 18

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: 06 (Month) 07 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 ROCKSIDE RD
BEDFORD HEIGHTS, OH 44146

4. Date post RU-486 event began:
6-21-12

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: Ø Hours 1 Days

7. Remarks:

8. a. Name of physician who provided RU-486 DR DAVID BANKOWSKI

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

Date 6/27/12

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

MEDICAL BOARD
JUL 09 2012

Prescribed: 5/--/2011

Report #27

# State Medical Board of Ohio
# Report of RU-486 Event

MEDICAL BOARD
SEP 10 2012

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: June (Month) 12 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25360 Rockside Rd
Bedford Hts, OH

4. Date post RU-486 event began:
6/29/12

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: ___1___ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Sarah K Smith MD

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

Date 9/4/12

Send completed forms to:

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

Prescribed: 5/--/2011

Report #29

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: July (Month) 3 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd
Bedford Hts, OH 44146

4. Date post RU-486 event began:
7/19/2012

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 ___1___ Days

7. Remarks:

8. a. Name of physician who provided RU-486 David Burkons, MD

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

Date 1/18/13

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

MEDICAL BOARD
JAN 24 2013

Prescribed: 5/--/2011

Report #38

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: 7 (Month) 17 (Day) 12 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
PLANNED PARENTHOOD OF GREATER OHIO

3. Address of medical practice or facility at which RU-486 was provided:
25350 ROCKSIDE RD, BEDFORD HTS, OH 44146

4. Date post RU-486 event began:

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

- ✓ Incomplete abortion
- ___ Adverse reaction to RU-486
- ___ Patient hospitalized
- ___ Patient received a transfusion
- ___ Severe bleeding
- ___ Other serious event (specify) _____

6. Duration of event: 4 Hours 8 Days

7. Remarks:

MEDICAL BOARD
APR 15 2013

8. a. Name of physician who provided RU-486 DR SARAH LENGEN

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

Date 4/9/13

Send completed forms to:

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

Prescribed: 5/--/2011

Rpt 19

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: 06 (Month) 15 (Day) 12 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
12000 Shaker Blvd. Cleve. OH 44120

4. Date post RU-486 event began:
09/08/12

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

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

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks:
Abortion completed surgically 9/8/12, no further complications.

8. a. Name of physician who provided RU-486 Rebecca Lowenthal, M.D.

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

Date 9/21/12

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

MEDICAL BOARD
SEP 24 2012

Prescribed: 5/--/2011

Report #30

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: August (Month) 30 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd, Bedford Hts, OH 44146

4. Date post RU-486 event began:
9/15/2012

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 1 ~~3~~ error Days

7. Remarks:

8. a. Name of physician who provided RU-486 David Burkons, MD

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

Date 1/18/13

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

MEDICAL BOARD
JAN 24 2013

Prescribed: 5/--/2011

Rept 20

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: 08 (Month) 30 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
12000 Shaker Blvd. Cleve. OH 44120

4. Date post RU-486 event began: 9/12/12

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

✓ Incomplete abortion
___ Adverse reaction to RU-486
___ Patient hospitalized
___ Patient received a transfusion
___ Severe bleeding
___ Other serious event (specify) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks:
Abortion completed surgically 9/12/12, no further complication.

8. a. Name of physician who provided RU-486 Lisa Pereira, M.D.

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

Date 9/14/12

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



Prescribed: 5/--/2011

Rpt # 28

# State Medical Board of Ohio
# Report of RU-486 Event

MEDICAL BOARD
NOV 30 2012

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: 9 (Month) 12 (Day) 12 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
CENTRAL OHIO WOMEN'S CENTER

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. MAIN STREET Col's, Oh. 43213

4. Date post RU-486 event began:
10/12/12

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: 24 Hours Ø Days

7. Remarks: Pt underwent D&C for incomplete medical abortion.

8. a. Name of physician who provided RU-486 Dr. Reder

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

Date 10/12/12

STATE MEDICAL BOARD OF OHIO
2012 NOV 30 PM 2:00

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

Prescribed: 5/--/2011

Report 44

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: 9 (Month) 12 (Day) 12 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Central Ohio Women's Center

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. MAIN STREET COLUMBUS, OHIO 43213

4. Date post RU-486 event began: 9-28-12

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

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

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks: No heavy bleeding. desired D and C for completion so IUD could be inserted.

8. a. Name of physician who provided RU-486 Dr. Keder

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

Date 11/21/12

Send completed forms to:

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

MEDICAL BOARD
JUL 9 – 2013

Prescribed: 5/--/2011

Report #31

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: Sept (Month) 18 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd, Bedford Hts, OH 44146

4. Date post RU-486 event began:
10/2/12

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 1 Days

7. Remarks:

8. a. Name of physician who provided RU-486 Sarah Smith, MD

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

Date 1/15/13

Send completed forms to:

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

MEDICAL BOARD
JAN 24 2013

Prescribed: 5/--/2011

Report #33

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: 10 (Month) 17 (Day) 2012 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
PLANNED PARENTHOOD OF GREATER OHIO

3. Address of medical practice or facility at which RU-486 was provided:
25350 ROCKSIDE RD
BEDFORD HTS, OH 44146

4. Date post RU-486 event began:
11-8-12

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: 1 Hours 0 Days

7. Remarks:

8. a. Name of physician who provided RU-486 DR DAVID BURKONS, MD

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

Date 1/16/13

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

MEDICAL BOARD
JAN 24 2013

Prescribed: 5/--/2011

Report #36

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: 10 (Month) 17 (Day) 2012 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
PLANNED PARENTHOOD OF GREATER OHIO

3. Address of medical practice or facility at which RU-486 was provided:
25350 ROCKSIDE RD
BEDFORD HTS, OH 44146

4. Date post RU-486 event began:
10/27/12

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: 8 Hours 2 Days

7. Remarks:

8. a. Name of physician who provided RU-486 DR. DAVID BURGONS, M.D.

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

Date 1/18/13

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

MEDICAL BOARD
JAN 24 2013

Prescribed: 5/--/2011

Report #32

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: 10 (Month) 31 (Day) 2012 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
PLANNED PARENTHOOD OF GREATER OHIO

3. Address of medical practice or facility at which RU-486 was provided:
25350 ROCKSIDE RD
BEDFORD HTS, OH 44146

4. Date post RU-486 event began:
11/16/12

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) INFECTION

6. Duration of event: 0 Hours 14 Days

7. Remarks: TREATED WITH PO ANTIBIOTICS x 14 DAYS

8. a. Name of physician who provided RU-486 Dr DAVID BURKONS, M.D.

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

Date 1/16/13

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

MEDICAL BOARD
JAN 24 2013

Prescribed: 5/--/2011

Report #34

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

**To be completed by the physician who provided RU-486**

| | | | |
|---|---|---|---|
| 1. Date RU-486 was provided: | 11 (Month) | 8 (Day) | 2012 (Year) |

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

PLANNED PARENTHOOD OF GREATER OHIO

3. Address of medical practice or facility at which RU-486 was provided:

25350 RICKSIDE RD, BEDFORD HTS, OH 44146

4. Date post RU-486 event began:

11/27/12

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: Ø Hours 3 Days

7. Remarks:

8. a. Name of physician who provided RU-486 DR DAVID BLERKOMS, MD

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

Date 1/8/13

Send completed forms to:

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

MEDICAL BOARD
JAN 24 2013

Prescribed: 5/--/2011

Report # 35

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

| | | | |
|---|---|---|---|
| 1. Date RU-486 was provided: | 11 (Month) | 14 (Day) | 2012 (Year) |

2. Name of medical practice or facility at which RU-486 was provided:
PLANNED PARENTHOOD OF GREATER OHIO

3. Address of medical practice or facility at which RU-486 was provided:
25350 ROCKSIDE RD
BEDFORD HTS, OH 44146

4. Date post RU-486 event began:
11/30/12

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) HEMATOMETRA TREATED WITH ASPIRATION

6. Duration of event: <1 Hours 8 Days

7. Remarks:

8. a. Name of physician who provided RU-486 DR DAVID BURKONS, MD

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

Date 1/18/13

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

MEDICAL BOARD
JAN 24 2013

Prescribed: 5/--/2011

Report #37

# State Medical Board of Ohio
# Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

**To be completed by the physician who provided RU-486**

1. Date RU-486 was provided: 12 (Month) 11 (Day) 2012 (Year)

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

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

4. Date post RU-486 complication began: 1/2/13

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: ~~X~~ zero Hours 7 Days

7. Remarks:
Abortion completed surgically on 1/9/13, no further complication.

8. a. Name of physician who provided RU-486 Mohammad Rezaee

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

Date 1/22/13

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

MEDICAL BOARD
JAN 28 2013

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