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: January (Month) 13 (Day), 2015 (Year)

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

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 complication began: 1/30/15

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: N/A Hours _____ Days

7. Remarks:
failed secondary to FDA protocol

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

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

Date 2/3/15

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

MEDICAL BOARD
FEB 9 2015

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

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: 01 (Month) 21 (Day) 2015 (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 44120

4. Date post RU-486 complication began:
02/06/15

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.

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

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

Date 2/18/15

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

MEDICAL BOARD
FEB 20 2015

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

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: 01 (Month) 22 (Day) 15 (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 44120

4. Date post RU-486 complication began:
2/13/15

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.

8. a. Name of physician who provided RU-486 Lisa Herrera

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

Date 2/26/15

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

MEDICAL BOARD
MAR 2 2015

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

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 2 (Month) 17 (Day) 2015 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave.

4. Date post RU-486 complication began:
3/6/15

MEDICAL BOARD
AUG 3 2015

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 14 Days Follow up period after meds.

7. Remarks:
Pt. did well with second dose of misoprostol

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

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

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

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: 03 (Month) 10 (Day) 15 (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 44120

4. Date post RU-486 complication began: 04/03/15

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: 3 Hours _____ Days

7. Remarks:
Abortion completed surgically.

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

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

Date 4/14/15

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

MEDICAL BOARD
APR 20 2015

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

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: 03 (Month) 12 (Day) 15 (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 44120

4. Date post RU-486 complication began: 03/28/15

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.

8. a. Name of physician who provided RU-486 Lisa Pentiera

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

Date 4/16/15

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

MEDICAL BOARD
APR 20 2015

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

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: 05 (Month) 06 (Day) 2015 (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 44120

4. Date post RU-486 complication began:
6/2/15

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.

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

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

Date 6/2/15

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

MEDICAL BOARD
JUN 5 2015

Prescribed: 5/—/2011, Rev. 12/13/12

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: 6 (Month) 2 (Day) 15 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave Cincinnati, OH 45219

4. Date post RU-486 complication began:
6/18/15

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 30 Days Follow up period after meds

7. Remarks:
pt. elected to attempt completion with second dose of miso prostol, had D&C on 7/21/15 without problem

8. a. Name of physician who provided RU-486 Sharon Lin

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

Date 7/24/15

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

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

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 06 (Month) 10 (Day) 15 (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 44120

4. Date post RU-486 complication began:
7/3/15

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.

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

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

Date 7/16/15

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

MEDICAL BOARD
JUL 20 2015

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

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 06 (Month) 11 (Day) 15 (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 44120

4. Date post RU-486 complication began: 7/7/15

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

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

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

Date 7/16/15

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

MEDICAL BOARD
JUL 20 2015

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

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 06 (Month) 16 (Day) 15 (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 44120

4. Date post RU-486 complication began: 7/10/15

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: 2.5 Hours _____ Days

7. Remarks:
Abortion completed surgically.

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

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

Date 7/14/15

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

MEDICAL BOARD
JUL 20 2015

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

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: 09 (Month) 10 (Day) 15 (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 44120

4. Date post RU-486 complication began: 10/01/15

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.

8. a. Name of physician who provided RU-486 Mitchell Raiden, M.D.

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

Date 10/10/15

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

MEDICAL BOARD
OCT 15 2015

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

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: 09 (Month) 24 (Day) 15 (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 44120

4. Date post RU-486 complication began: 10/10/15

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.

8. a. Name of physician who provided RU-486 Mitchell Eidem, M.D.

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

Date 10/16/15

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

MEDICAL BOARD
OCT 19 2015

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

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: October 13, 2015
   Month Day Year

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

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 complication began:
   10/29/2015

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: incomplek medication abortion following FDA approved. protocol.

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

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

Date 10/28/15

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

MEDICAL BOARD
NOV 2 2015

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

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: 11 (Month) 04 (Day) 2015 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave, Cincinnati, OH 45219

4. Date post RU-486 complication began:
11/20/15

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:
D+C performed w/o incident.

8. a. Name of physician who provided RU-486 [signature]

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

Date 12/4/15

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

MEDICAL BOARD
DEC 09 2015

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

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: May (Month) 28 (Day) 2014 (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:
07/17/2014

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: Pt underwent FDA approved protocol for medication abortion with (+) pregnancy test 6 weeks later, bloodwork confirms incomplete abortion. Treated with misoprostol 800 mcg without complication.

8. a. Name of physician who provided RU-486 Timothy Kress, MD

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

Date 7/17/14

Send completed forms to:

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

MEDICAL BOARD
SEP 26 2014

Prescribed: 5/--/2011

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 06 (Month) 03 (Day) 14 (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 44120

4. Date post RU-486 complication began:
06/20/14

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:
Abortion completed surgically.

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

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

Date 7/9/14

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

MEDICAL BOARD
JUL 14 2014

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

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: 07 (Month) 03 (Day) 14 (Year)

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

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

4. Date post RU-486 complication began:
8/2/14

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:
Abortion completed surgically.

8. a. Name of physician who provided RU-486 Lisa Perricone

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

Date 8/8/14

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

MEDICAL BOARD
AUG 11 2014

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

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: August (Month) 20 (Day) 2014 (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 Heights, OH 44146

4. Date post RU-486 event began: 9/6/2014

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: Pt underwent FDA approved protocol for medication abortion with continuing viable pregnancy at followup. Pt elected surgical aspiration which was performed without complication.

8. a. Name of physician who provided RU-486 Timothy Kress, MD

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

Date 9/6/14

Send completed forms to:

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

MEDICAL BOARD
SEP 26 2014

Prescribed: 5/--/2011

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) 26 (Day) 2014 (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:
9/10/14

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) _____

MEDICAL BOARD
SEP 29 2014

6. Duration of event: _____ Hours 14 Days

7. Remarks: pt received medication abortion per FDA approved protocol. intrauterine debris on ultrasound at 14 day followup visit without viable pregnancy. Treated with 2 courses misoprostol without complication. Complete abortion confirmed by ultrasound.

8. a. Name of physician who provided RU-486 Timothy Kress, MD

8. b. Physician's signature Timothy S Kress M.D. / D.O

Date 9/24/14

Send completed forms to:

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

Prescribed: 5/--/2011

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: 08 (Month) 28 (Day) 14 (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 44120

4. Date post RU-486 complication began: 09/12/14

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 _____ Days

7. Remarks:
Abortion completed surgically.

8. a. Name of physician who provided RU-486 Lisa Perriera

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

Date 9/19/14

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

MEDICAL BOARD
SEP 22 2014

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

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: August 28, 2014 (Month / Day / Year)

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

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

4. Date post RU-486 complication began:
September 12, 2014

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: n/a Hours _____ Days

7. Remarks:
FDA protocol resulted in incomplete procedure

8. a. Name of physician who provided RU-486 Catherine Karanos M.D.

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

Date 9/16/2014

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

MEDICAL BOARD
SEP 19 2014

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

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: 10 (Month) 08 (Day) 14 (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 44120

4. Date post RU-486 complication 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: 2 Hours _____ Days

7. Remarks:
Abortion completed surgically.

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

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

Date 10/15/14

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

MEDICAL BOARD
NOV 20 2014

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

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: 10 (Month) 23 (Day) 14 (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 complication began:
11/8/14

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) _____

STATE MEDICAL BOARD OF OHIO
2014 NOV 18 AM 10: 08

6. Duration of event: 2 Hours _____ Days

7. Remarks:
Abortion completed surgically.

8. a. Name of physician who provided RU-486 Lisa Perriera

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

Date 11/14/14

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

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

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) 28 (Day) 2014 (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: 12/12/2014

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 TIMOTHY KRESS, MD

8. b. Physician's signature Timothy Kress M.D. / ~~D.O~~

Date 12/12/14

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

MEDICAL BOARD
DEC 17 2014

Prescribed: 5/--/2011

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: 11/18/2014 (Month / Day / Year)

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

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 complication began: 12/09/2014

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: NA Hours _____ Days

7. Remarks: failed medical AB likely result of FDA protocol.

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

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

Date 12/9/14

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

MEDICAL BOARD
DEC 11 2014

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

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) 17 (Day) 2014 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave
Cincinnati, OH 45219

4. Date post RU-486 complication began: 12/30/14

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:

8. a. Name of physician who provided RU-486 Sharon Lin

8. b. Physician's signature _____ MD/DO

Date 2/18/15

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

MEDICAL BOARD
FEB 23 2015

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