

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided	- Januar Month	4 13, 2015 Pay Year
2. Name of medical practice of PPOH	or facility at which RU-486 was provid	ed:
[- [- [- [- [- [- [- [- [- [-	or facility at which RU-486 was provi	
4. Date post RU-486 complica	tion began: 1 30 19	
5. Event(s) (Please check all the last of	Adverse reaction to RU-486	Patient hospitalized
Other serious event (specify) _		
6. Duration of event: N/	Hours Days	
7. Remarks: Failed	secondary to FDI	putocol
8. a. Name of physician who per second secon	Date — Cath	s/3/15
	State Medical Board of Ohio Legal Department 30 E. Broad St., 3 rd Floor Columbus, OH 43215-6127	MEDICAL DOARD FEB 9 2015

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

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

	01	21	2015
	Month	Day	Year
2. Name of medical practice or facility at v	which RU-486 was provi	ded:	
3. Address of medical practice or facility at			
12000 Shaker Blvd.	Cleveland	44120	
4. Date post RU-486 complication began: 02/06/15			
5. Event(s) (Please check all that apply):			
Incomplete abortionA	dverse reaction to RU-486	Patient hospitaliz	ed
	arcide reaction to the reaction	ration nospitaliz	
Patient received a transfusion Severe blee	eding		
			,
Other serious event (specify)			
6. Duration of event: 2 Hours	Days		
6. Duration of event: 2 Hours	Days		
7. Remarks:			
7. Remarks:			
7. Remarks: Abortion completed	Surgically.	1 110 2.1	
7. Remarks: Abortion completed	Surgically.	Lell Reid	es -
7. Remarks: Abortion completed	Surgically.	Lell Reid	er)no_
7. Remarks: Abortion completed 8. a. Name of physician who provided RM	Surgically.	Lell Reid	er) D.O

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

FEB 2 0 2015

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	01	22	15
	Month	Day	Year
2. Name of medical practice or facility at	which RU-486 was provid	ed:	
3. Address of medical practice or facility a	t which RU-486 was provi	ded:	
12000 Shaker Blvd.	Cleveland	4413	20
4. Date post RU-486 complication began: 2/13	15		
5. Event(s) (Please check all that apply):	1		
	Adverse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Severe bloom	eeding		
Other serious event (specify)			
6. Duration of event:2 Hours _	Days		
7. Remarks:	111	0	
Abortion comp	Heted Surgicals	9.	
8. a. Name of physician who provided RU	J-486 <u>LISA</u>	Aerriera	
8. b. Physician's signature		MD	/D.O
	Date 0 06/1	5	
Send completed forms to: State	e Medical Board of Ohio		
Legal Depar	tment		
30 E. Broad	St., 3 rd Floor		

Columbus, OH 43215-6127

MAR 2 2015

MEDICAL BOARD



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	2	17-	2015
	Month	Day	Year
2. Name of medical practice or facility at wh Planned Parenthood	"레이크 : [1] [1] - "라그리 글로 150 [1] ^^ 라스티 - 트립션		Resion
3. Address of medical practice or facility at was 2314 Auburn Am.	vhich RU-486 was provid	led:	
4. Date post RU-486 complication began:		MEDIC	AL BOARD
5. Event(s) (Please check all that apply):	rerse reaction to RU-486	AUG Patient hospitalize	
Patient received a transfusion Severe bleed	ling		
Other serious event (specify)			
6. Duration of event: Hours/	4 Days Fallow	up period	after medo
7. Remarks: Pt. did wall with sa	cand don on	t misoph	550/
8. a. Name of physician who provided RU-48	86 <u>Dr</u>	Kulsy	
8. b. Physician's signature	Date	M.D.,	100
Send completed forms to: State M	ledical Board of Ohio		
Legal Departme			
30 E. Broad St.,			
Columbus, OH	43215-6127		



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:		03	10	15
		Month	Day	Year
2. Name of medical practice or fac	cility at which R	U-486 was provi	ded:	
3. Address of medical practice or f				
12000 Snaker	Blvd.	Clevela	nd 4	4120
4. Date post RU-486 complication		103/15		
5. Event(s) (Please check all that a		1		
Incomplete abortion	Adverse re	eaction to RU-486	Patient hospitaliz	red
Patient received a transfusion S	Severe bleeding			
Other serious event (specify)				
6. Duration of event: 3	Hours	_ Days		
7. Remarks:	pleted su	rgically.		
8. a. Name of physician who provi	ded RU-486	Moha	mucal Re	zall
8. b. Physician's signature	Date	My se	15 MD	0.0
Send completed forms to:		al Board of Ohio		
	Department	a Dourd of Office		
	Broad St., 3 rd F	loor	MEDICAL	BOARD
Colu	mbus, OH 4321	15-6127	APR 20	



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provide	d:	03	12	15
		Month	Day	Year
2. Name of medical practice	or facility at which	n RU-486 was provid	led:	
3. Address of medical practic	ce or facility at whi	ich RU-486 was prov	rided:	
12000 Shok				D
4. Date post RU-486 complic	cation began:	3/28/15		
5. Event(s) (Please check all	that apply):	1 1.		
Incomplete abortion		se reaction to RU-486	Patient hospitalize	d .
Patient received a transfusion	n Severe bleedin	g		
Other serious event (specify)		•		
6. Duration of event:2	Hours	Days		
7. Remarks:	completed	swajcally.		
8. a. Name of physician wh	o provided RU-486	6 Lisa	Petriera	
8. b. Physician's signature	THE	Date 4/14/		/DO
Send completed forms to:	State Me	edical Board of Ohio		
	Legal Departme	nt		
	30 E. Broad St.,	3 rd Floor	MEDICAL	L BOARD
	Columbus, OH	43215-6127	APR 2	0 2015



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provide	ed:	05	06	2015
		Month	Day	Year
2. Name of medical practice Arefet vn	e or facility at which	RU-486 was provi	ded:	
3. Address of medical practi				
4. Date post RU-486 compli	cation began:			
5. Event(s) (Please check all				
Incomplete abortion	Adverse	e reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion	n Severe bleeding			
Other serious event (specify)				
6. Duration of event:	2Hours	Days		
7. Remarks:	completed	surgically.		
8. a. Name of physician who	provided RU-486	Moha	mucel Pas	ace, 4.0.
8. b. Physician's signature	ANN/ Da	ate 19	0/2/15)DO
Send completed forms to:	State Med	ical Board of Ohio	,	
	Legal Department			7
	30 E. Broad St., 3 ^{rt}	d Floor	2 50000	10.11 00:00
	Columbus, OH 43	215-6127	MED	ICAL BOARD

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

JUN 5 2015



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	4	2	15
	Month	Day	Year
2. Name of medical practice or facility at when Planned Parenths			
3. Address of medical practice or facility at a 2314 Aubum Ave			219
4. Date post RU-486 complication began:			OFFICAL BUSINE
5. Event(s) (Please check all that apply): ——Adv	verse reaction to RU-486		AUG 3
Patient received a transfusion Severe blee Other serious event (specify)	ding		
6. Duration of event: Hours	30 Days Foll	19 an ac	riod after mu
7. Remarks: pt. etected to attended niso prostol, had	not complete	tion with 7/21/15	seand oble of without public
8. a. Name of physician who provided RU-4	0.86 /h.	aron bi	200
Send completed forms to: State N Legal Departm 30 E. Broad St.			



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provide	ed:	06	10	15
		Month	Day	Year
2. Name of medical practice Arelet m	e or facility at whic	ch RU-486 was prov	vided:	
3. Address of medical practi	ice or facility at wh	nich RU-486 was pro	ovided:	
12000 Sheker	- Blud.	Cleveland	44120	
4. Date post RU-486 compli	cation began:	15		
5. Event(s) (Please check all	7 1			
Incomplete abortion	Adver	rse reaction to RU-486	Patient hospitalize	d .
Patient received a transfusio	n Severe bleedir	ng		
Other serious event (specify)			•	
6. Duration of event:	Hours	Days		
7. Remarks:				
Abortion co	ruptered 5	urgically.		
8. a. Name of physician who	provided RV 489	6 M	thell Rich	der
8. b. Physician's signature		Date 7	116/15	/ D.O
Send completed forms to:	State Me	edical Board of Ohio		
	Legal Departme			
	30 E. Broad St.,		MEDICAL B	OARD
	Columbus, OH 4	43215-6127		
			JUL 202	UIJ

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

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

. Date RU-486 was provided:	06	//	15
	Month	Day	Year
2. Name of medical practice or facility at	which RU-486 was provide	ed:	
3. Address of medical practice or facility a	at which RU-486 was provi	ded:	
12000 Shaker Blud	. Cheveland	44120	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):	11		
Incomplete abortion	Adverse reaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion Severe b	oleeding		
Other serious event (specify)			
6. Duration of event: 2 Hours	Days		
7. Remarks: Abortion completed	1 Swgicelly		
8. a. Name of physician who provided R 8. b. Physician's signature	Date 7/14/13	Loll Ceid	ler),00
Send completed forms to: Sta	te Medical Board of Ohio		
Legal Depa			
30 E. Broad	d St., 3 rd 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:	06	16	15
	Month	Day	Year
2. Name of medical practice or facility Areter m	at which RU-486 was provid	ded:	
3. Address of medical practice or facility			
12000 Shaker Blva	d. Cleveland	44120	
4. Date post RU-486 complication beg	7/10/15		
5. Event(s) (Please check all that apply			
/Incomplete abortion	Adverse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Sever	re bleeding		
Other serious event (specify)	•		
6. Duration of event: 2.5 Hou	rs Days		
7. Remarks:			
Abortion comple	had sugically.		
8. a. Name of physician who provided	RU-486 Moha	munael Roz	iace
8. b. Physician's signature	More 1/	14/15	0.0
Send completed forms to:	State Medical Board of Ohio	1	
	epartment		
	oad St., 3 rd Floor		
Columb	us, OH 43215-6127	MEDIC/	AL BOARD

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

JUL 2 0 2015



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	09	10	15
	Month	Day	Year
2. Name of medical practice or facility a	at which RU-486 was provide	ded:	
3. Address of medical practice or facility 12,000 Shaker Blvd.	at which RU-486 was prov	vided: //2 D	
4. Date post RU-486 complication began			
5. Event(s) (Please check all that apply):			
Incomplete abortion	_ Adverse reaction to RU-486	Patient hospitali	zed
Patient received a transfusion Severe	bleeding		
Other serious event (specify)			
6. Duration of event: 2 Hours	S Days		
7. Remarks: Abortion complete	tel surgically.		
8. a. Name of physician who provided I 8. b. Physician's signature	Date 10/10/	1- (-	n, M.D.
Send completed forms to: Sta	ate Medical Board of Ohio		
Legal Dep	artment		
30 E. Broa	nd St., 3 rd Floor		
Columbus	s, OH 43215-6127		

MEDICAL BOARD

OCT 1 5 2015



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

. Date RU-486 was provided:	09	24	15
, Date in	Month	Day	Year
. Name of medical practice or facility at	t which RU-486 was prov	ided:	
3. Address of medical practice or facility 12000 Shaker Blvd.	at which RU-486 was pro	ovided: 44120	
4. Date post RU-486 complication began	10/10/15		
5. Event(s) (Please check all that apply):			
	_ Adverse reaction to RU-486	Patient hospitaliz	zed .
Patient received a transfusion Severe Other serious event (specify)			
6. Duration of event: 2 Hours			
7. Remarks: Abortion completed	surgically.		
8. a. Name of physician who provided 8. b. Physician's signature	RU-486 Mil-	hell Reider) n.o.
Send completed forms to: St	rate Medical Board of Oh	io	
Legal Dep	partment		
30 E. Bro	ad St., 3 rd Floor		

Columbus, OH 43215-6127

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

MEDICAL DOARD

OCT 19 2015



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:		40bex	13, 2013 Day	> Year
2. Name of medical practice or fac	ility at which RU-48	86 was provid	ded:	
3. Address of medical practice or fa	acility at which RU-	486 was prov	vided:	
3255 East Main	St. Columbi	13,04	43213	
4. Date post RU-486 complication 10 29 2015	began:			
5. Event(s) (Please check all that a	pply):			
/Incomplete abortion	Adverse reaction	on to RU-486	Patient hospita	ilized
Patient received a transfusion 5 Other serious event (specify)				
6. Duration of event:I	Hours Da	Bys		
7. Remarks: Incomplete med protocol.	lication abou	tion fo	110 wing	FD A approved.
8. a. Name of physician who provi	ded RU-486	Cox	thering Ra	nanos
8. b. Physician's signature	Date —	10/	28/1 M	0.00_
Send completed forms to:	State Medical Bo	oard of Ohio		
	l Department			
	Broad St., 3 rd Floor		MED	ICAL BOARD
Colu	mbus, OH 43215-6	127	N. Carlotte	DV 9 2015



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	Month	0 4	2015 Year
2. Name of medical practice or facility of anneal Parenths.	y at which RU-486 was p	provided:	163
3. Address of medical practice or facil			5219
4. Date post RU-486 complication beg	gan:		
5. Event(s) (Please check all that appliance of the serious event (specify)	Adverse reaction to RU-	486 Patient hospitali	ized
6. Duration of event: 1 Hou	urs Days		
7. Remarks: D+ (performed)	(W/3 in ci	dut.	
8. a. Name of physician who provided 8. b. Physician's signature	11/2/	12/4/15	2/00
Legal De 30 E. Br	State Medical Board of Cepartment oad St., 3 rd Floor us, OH 43215-6127	MEDICAL F	30ARD 2015



(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

		THE RESERVE THE PARTY OF THE PA	
1. Date RU-486 was provided:	May	28	2014
	Month	Day	Year
	facility at which RU-486 was provided		
			-
	or facility at which RU-486 was provi		46
25350 ROURSIDE	, 00, 100, 1, 1, 1,		1 4
4. Date post RU-486 event beg	1/		
5. Event(s) (Please check all th	nat apply):		
Incomplete abortion	Adverse reaction to RU-486	Patient ho	ospitalized
Patient received a transfusion	Severe bleeding		
Other serious event (specify)			
6. Duration of event:	Hours l Days		
pregnancy test 6 weeks	FDA approved protocol for me later, bloodwork confirms inco ncg without complication.	dication a	bortion with & cortion. Treated
8 a Name of physician who p	rovided RU-486 Timothy K	ress, MD	
	Kin		£M.D. ∂D.O
8. b. Physician's signature _	Date 7/(7/14	<u> </u>	WI.D. 00.0
Send completed forms to:	State Medical Board of Ohio		
	Legal Department	MI	EDICAL BOARD
	30 E. Broad St., 3 rd Floor		
	Columbus, OH 43215-6127		SEP 2 6 2014

Prescribed: 5/--/2011



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provide	d:	06	03	14
		Month	Day	Year
2. Name of medical practice Are Jerm	or facility at which F	RU-486 was provid	ed:	
3. Address of medical praction	ce or facility at which	RU-486 was prov	ided:	
12000 Shaker	Blud. Cles	reland	44120	
4. Date post RU-486 complic	06/20/14			
5. Event(s) (Please check all				
Incomplete abortion	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: Abortion comple	ted surgically	1		
8. a. Name of physician who	provided RU-486	Mohan	med Rezere	, и.б.
8. b. Physician's signature	All Dat	7	(9/14 (MD)	'D.O
Send completed forms to:		cal Board of Ohio	//	
seria compietea forms to:	Legal Department	ai buaiu ui Uiilu		
	30 E. Broad St., 3 rd	Floor	MEDICAL	BOARD
	Columbus, OH 432			
			JUL 1	2014



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:		07	03	14
		Month	Day	Year
2. Name of medical practice or fa	cility at which RU	J-486 was prov	ided:	
3. Address of medical practice or f	facility at which I	RU-486 was pro	vided:	
12000 Shakes /	Blvd.			
4. Date post RU-486 complication	began:			
5. Event(s) (Please check all that a	pply):	-		,
Incomplete abortion	Adverse rea	action to RU-486	Patient hospitalize	d
Patient received a transfusion	Severe bleeding			
Other serious event (specify)				-
6. Duration of event:	Hours	Days		
7. Remarks:	-			
Abortion complete	ed surgica	007.		
8. a. Name of physician who provides 8. b. Physician's signature	A	\$150 8/81	Aeriera/	DO.
	Date	- 1/	7	
Send completed forms to:	State Medical	Board of Ohio		
	Department			, gill
	Broad St., 3 rd Flo			CAL BOARD
Colur	mbus, OH 43215	5-6127		Est John



(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	Avaust	20	2014
	Month	Day	Year
	facility at which RU-486 was provood of Greater Ohio	rided:	
	or facility at which RU-486 was pro		
4. Date post RU-486 event beg	an: 9/6/2014		
5. Event(s) (Please check all the Incomplete abortion Patient received a transfusion Other serious event (specify)	Adverse reaction to RU-486 Severe bleeding	Patient h	ospitalized
6. Duration of event:	Hours Days		
with continuing viable	nt FDA approved protoco pregnancy at followup performed without con	o. Pt elect	ed surgical
8. a. Name of physician who pr 8. b. Physician's signature —	Turny for Date 9/6/14	w	M.D. D.O
Send completed forms to:	State Medical Board of Ohio Legal Department 30 E. Broad St., 3 rd Floor Columbus, OH 43215-6127	М	EDICAL BOARD SEP 2 6 2014

Prescribed: 5/-/2011



Prescribed: 5/--/2011

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provided:	August	26 2014
	Month	Day Year
	acility at which RU-486 was provi	
	Ro, BED FORD HT3, o	
4. Date post RU-486 event bega	n	
5. Event(s) (Please check all that Incomplete abortion	t apply): Adverse reaction to RU-486	Patient hospitalized
Patient received a transfusion	Severe bleeding MI	EDICAL BOARD
Other serious event (specify)		SEP 2 9 2014
6. Duration of event:	Hours 14 Days	• •
debnis on ultrasound at 14	t day followup visit withou	roved protocol. Intravterine t viable pregnancy. Treated mplete abortion confirmed
8. a. Name of physician who pro	vided RU-486 Timothy K	ress, MD
8. b. Physician's signature	Turing Sd	Knus (M.D.) D.O
	Date 9/241	14
Send completed forms to:	State Medical Board of Ohio Legal Department 30 E. Broad St., 3 rd Floor	
	Columbus, OH 43215-6127	



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provid	led:	08	28	14
		Month	Day	Year
2. Name of medical practic	ce or facility at which R	U-486 was provi	ded:	
3. Address of medical pract	ice or facility at which	RU-486 was pro	vided:	
12000 Shak				
4. Date post RU-486 compl	ication began:	9/12/14		
5. Event(s) (Please check al		/ /		
V				
Incomplete abortion	Adverse re	eaction to RU-486	Patient hospitalized	
Patient received a transfusion	on Severe bleeding			
Other serious event (specify)			
6. Duration of event:	Hours	_ Days		
7. Remarks:	- completed	surgically	<i>y</i> .	
8. a. Name of physician who	o provided RU-486	Lisa	Lettiera	
	PA			
8. b. Physician's signature	Date	9/10	114 MD/D	.0
Send completed forms to:	State Medica	Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd Fl	oor		
	Columbus, OH 4321	5-6127	MEDICAL BOA	ARD
			SEP 2 2 2014	



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	Avaust	28,2014	
	Month	Day	Year
2. Name of medical practice or facility a	et which RU-486 was prov	ided:	
3. Address of medical practice or facility 3255 Gust Min Street	at which RU-486 was pro	vided:	
Columbus, 0H 43213			
4. Date post RU-486 complication began	1;		
5. Event(s) (Please check all that apply):			
Incomplete abortion	_ Adverse reaction to RU-486	Patient hospital	ized
Patient received a transfusion Severe	bleeding		
Other serious event (specify)			The state of the s
6. Duration of event: Na Hours	Days		
7. Remarks: FO A protocol rosu	uted in Inco	implife 1	madure
8. a. Name of physician who provided 8. b. Physician's signature	RU 486 Cather	ane Kan	
	Date	<u> </u>	
Send completed forms to: St	ate Medical Board of Ohio		
Legal Dep	artment	e manufacture de la constante	
30 E. Broa	nd St., 3 rd Floor	ME	DICAL BOARD
Columbus	s, OH 43215-6127		SEP 1 9 2014



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	10	08	14
	Month	Day	Year
2. Name of medical practice or facility at	which RU-486 was provi	ded:	
3. Address of medical practice or facility a		,	120
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply): Incomplete abortion Patient received a transfusion Other serious event (specify)		Patient hospitalize	d
6. Duration of event: 2 Hours	Days		
7. Remarks: Albortion completed	surgically.		*
8. a. Name of physician who provided RU 8. b. Physician's signature	Date 10/15	114 MD	00
Send completed forms to: State Legal Depart	Medical Board of Ohio		
30 E. Broad	St., 3 rd Floor		

Columbus, OH 43215-6127

MEDICAL BOARD

NOV 2 0 2014



(Required pursuant to R.C. 2919.123)

 Date RU-486 was provide 	d:	10	23	14
		Month	Day	Year
2. Name of medical practice	or facility at which R	U-486 was provid	led:	
3. Address of medical practic	ce or facility at which	RU-486 was prov	ided:	
12000 Shaker	Blvd. Cla	ve. OH	44120	
4. Date post RU-486 complic	cation began:			
11/8/14				~ 0
5. Event(s) (Please check all	that apply):			2114 NOV 18
/				3
Vincomplete abortion	Adverse re	eaction to RU-486	Patient hospitalized	JIL NOV 18
•				
Patient received a transfusion	Severe bleeding			AM 10: 08
				10: 08
Other serious event (specify)				8
other serious event (speeny)				DECEMBER 1
	-			
6. Duration of event:2	Hours	_ Days		
7. Remarks:				
	/	an		
Abortion co	upleted sur	gically.		
	/			
8. a. Name of physician who	provided R/I-486	Lisa	Derriera	
			7 31143	
8. b. Physician's signature	700		(MD)/D.0	<u> </u>
	Date	1 11111		
Send completed forms to:	State Medica	al Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd F	loor		
	Columbus, OH 4321	5-6127		



Prescribed: 5/--/2011

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provided:	: 10	28 2014
	Month	Day Year
	r facility at which RU-486 was provide	
2 Addross of madical practice	an facility of which BU 400 was a said	
	No, BED FORD HTS, OH	
4. Date post RU-486 event beg	gan: 12/12/2014	
5. Event(s) (Please check all the	nat 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:		
3. a. Name of physician who pr	rovided RU-486 TIMOTHY K	RESS, MD
3. b. Physician's signature	Tunty Km	M.D./ D.O
	Date 12/12/14	-
Send completed forms to:	State Medical Board of Ohio Legal Department 30 E. Broad St., 3 rd Floor	MEDICAL BOAR
	Columbus, OH 43215-6127	DEC 1 7 2014



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided	d:		11/1	8/2014	+
		Month		Day	Year
2. Name of medical practice	or facility at wh	ich RU-486 was pr	rovided:		
3. Address of medical practic	e or facility at w	hich RU-486 was	provided:		
3255 East M	ain st.	Columbus	M	45213	3
4. Date post RU-486 complica	ation hegan:	2/09/201			
5. Event(s) (Please check all t					
✓ Incomplete abortion	Adve	erse reaction to RU-48	86 Pat	ient hospitalize	d
Patient received a transfusion	Severe bleedi	ng			
Other serious event (specify)					
6. Duration of event:	· Hours	Days			
7. Remarks: failed 1 Portocol.	nedical	No like	ly re	Sult o	1 FDA
8. a. Name of physician who 8. b. Physician's signature	-	Date	eninc S	Kaman 12/9/1	
Send completed forms to:	State Me	edical Board of Oh	nio		
	Legal Departme	nt			R
	30 E. Broad St.,	3 rd Floor			LBOM
	Columbus, OH	43215-6127	entranse universales		MEDICAL BOARD
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Prescribed: 5/--/2011, Rev. 12/13/12



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	12	17	2014
	Month	Day	Year
2. Name of medical practice or facility at	which RU-486 was provi	ded:	
Plannes	d Parenthood South	nwest chio	
3 Address of medical practice or facility	turbish Dir Age		
3. Address of medical practice or facility at 2314 Auburn Ave		/idea:	
ancinnah, ort 45219	f		
4. Date post RU-486 complication began:	12/30/14		
5. Event(s) (Please check all that apply):			
V			
Incomplete abortion A	dverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe ble	ading		
Severe die	eonig		
Other serious event (specify)			
6. Duration of event: 2 Hours			
o. Buration of event. Hours	Days		
7. Remarks:			
3. a. Name of physician who provided RU-	400 // 6	1.	-
	486	on war	
3. b. Physician's signature	alia o	MO/1	0.0
U	Date	115	
end completed forms to: State I	Medical Board of Ohio		
Legal Departm	nent	MEDICAL	BOARD
30 E. Broad St	., 3 rd Floor	MEDICAL	
Columbus OF	1 42215 6127	FFR 2	2015