

(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:		Jan	29	2014
		Month	Day /	Year
2. Name of medical practice of				
Northeast C	hie Wam	this Cont	è	
3. Address of medical practice  2121 STA  CALLLAGA	de Pl	ch RU-486 was provi		
4. Date post RU-486 complicated 2//	tion began:			
5. Event(s) (Please check all th	at apply):		MEDI	CAL BOARD
Incomplete abortion	Advers	e reaction to RU-486	Patient hospitalized	
Patient received a transfusion	Severe bleeding			
Other serious event (specify)				
6. Duration of event:	Hours/_/	2 Days		
Part 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1				
7. Remarks A had	persul	it but An	ulle sor	in elevated H
7. Remarks thad	was forme	eand liolic,	i complete	in Jab
8. a. Name of physician who p	rovided RU-486	) Dhy (	Bulkons 1	M.D
8. b. Physician's signature		ate 2/5/4	(mg/s	D.O
Send completed forms to:	State Med	dical Board of Ohio		
	Legal Departmen	t		
	30 E. Broad St., 3	<sup>rd</sup> Floor		
	Columbus, OH 43	3215-6127		



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

(Required pursuant to R.C. 2919.123)

MAR 8 2016

To be completed by the physician who provided RU-486

L. Date RU-486 was provided:	2	22	16
	Month	. Day	Year
2. Name of medical practice or facility at w Pawled Par	which RU-486 was provi	ded:	
3. Address of medical practice or facility at	_		
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Incomplete abortionA	dverse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Severe ble	eeding		
Other serious event (specify)			
6. Duration of event: \( \sum \alpha \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			
7. Remarks: Fulled MAB (1 FDA regimen	non viable 14	p) due to	•
8. a. Name of physician who provided RU	J-486	herine Ron	nanos
8. b. Physician's signature	Date	3/3/14	)/0.0
Send completed forms to: State Legal Depar	e Medical Board of Ohio	0	
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Columbus, OH 43215-6127



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

Month J-486 was proving the second control of the second control o		Year 20
RU-486 was pro	ovided:	20
		20
		20
16		
eaction to RU-486	Patient hospit	alized
_ Days		
rgically.		
Mohe	emmed Ro	2400
te	The state of the s	andro
	Days  rgically.  Moho	Days  rgically.  Mohammad Ro.  Cogues Co. C.

Legal Department

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

Date RU-486 was provided:	22	24	16
Date Ru-486 Was provided	Month	Day	Year
. Name of medical practice or facility at w	hich RU-486 was provide	ed:	
. Address of medical practice or facility at	which RU-486 was provid Cleveland	44120	•
. Date post RU-486 complication began:			
Incomplete abortion Ac	dverse reaction to RU-486 _	Patient hospitalized	
6. Duration of event: 2 Hours _	Days		
7. Remarks: Abortion completed	surgicully.		
	-486 Mohas	mund (Ceza	ee
8. a. Name of physician who provided RU	1.1/10-11		7 -
8. a. Name of physician who provided RU 8. b. Physician's signature	Date 46	MD MD	<u></u>
8. b. Physician's signature	megrer		<u></u>
8. b. Physician's signature	Date 4 6  Medical Board of Ohio		<u></u>

Columbus, OH 43215-6127

APR 11 2016



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

. Date RU-486 was provided:	3	2	16	
, bate no los	Month	Day	Year	
Name of medical practice or facility at Planned Parenthood	which RU-486 was provi	ded: Ohio P	esion	
. Address of medical practice or facility 2314 Auburn A	at which RU-486 was pro	vided:		
3/23/16		70.		
5. Event(s) (Please check all that apply):	_Adverse reaction to RU-486	Patient hospita	MEDICA APR 12	
Other serious event (specify)				
6. Duration of event: Hours	s Days			
7. Remarks: Doing well & D	)*L			esta desprésament à recommende de la principación d
8. a. Name of physician who provided 8. b. Physician's signature	RU-486 Date	1/2/16	Diner Dine	
Legal De	tate Medical Board of Oh partment pad St., 3 <sup>rd</sup> Floor	io		

Columbus, OH 43215-6127



(Required pursuant to R.C. 2919.123)

. Date RU-486 was provide	d:	23_	30	2016
Duic no		Month	Day	Year
. Name of medical practice	or facility at which	n RU-486 was prov	ided:	
. Address of medical practi	ce or facility at whi	ich RU-486 was pro	ovided:	
12000 Shaker				
1. Date post RU-486 complia 04/26/16	cation began:			
5. Event(s) (Please theck all	that apply):	*		
Incomplete abortion		se reaction to RU-486	Patient hospitaliz	ed .
Patient received a transfusion	on Severe bleedin	g		
Other serious event (specify	)		-	
6. Duration of event:	3 Hours	Days		
7. Remarks:	completed	Surgically	7 .	
8. a. Name of physician wh	no provided RU-48	6 Mitch	Ol Rider	M.D.
8. b. Physician's signature		MU	4/21/16 ME	<i>J</i> D.O
Send completed forms to:	State M	edical Board of Oh	io	
	Legal Departme			
	30 E. Broad St.,	3 <sup>rd</sup> Floor	MEDIC	AL BOARD



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

. Date RU-486 was provided:	April	Day	2016 Year
. Name of medical practice or facility at wh	ich RU-486 was pro	ovided: _ SWGICAL.	Center
3255 E Main St.  Date post RU-486 complication began:			3213
5. Event(s) (Please check all that apply):	verse reaction to RU-48	6 Patient hosp	oitalized
Other serious event (specify)  6. Duration of event: Hours			
7. Remarks: failed Medicati	ion albotion	continue	as broducing
8. a. Name of physician who provided RU- 8. b. Physician's signature	486 <u>Vo</u>	MANOS	4/25/110
Send completed forms to:  State  Legal Departr  30 E. Broad S		thio	MEDICAL BOARD

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-486

4255 E. Main St.  Date post RU-486 complication began:	RU-486 was provided:	27H 43	2B
1. Date post RU-486 complication began:	Columbus	27H 43	23
4255 E. Main St.  1. Date post RU-486 complication began:	Columbus	277 43	213
1. Date post RU-486 complication began:			
	110010		
<ol><li>Event(s) (Please check all that apply):</li></ol>			
	eaction to RU-486 Patier	nt hospitalized	
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks: D:C for bluding.			
8. a. Name of physician who provided RU-486 8. b. Physician's signature	Catherine Ro	MALOS D	.0
Da	te	4127/1	$\varphi$

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127

MAY 2 2016

MEDICAL BOARD



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

Date RU-486 was provided:		04	29	16
		Month	Day	Year
Name of medical practice or	facility at which R	U-486 was provid	ded:	
Address of medical practice of				D
. Date post RU-486 complicati	ion began:			
Event(s) (Please check all that	at apply):			
Incomplete abortion	Adverse	reaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion				
Other serious event (specify)				
6. Duration of event:	Hours	_ Days un	Known	
The state of the s		20 1 1		
Abortion complet				
7. Remarks:  Abortion completed  8. a. Name of physician who p			Q Reider,	M.D.
8. a. Name of physician who p		Mitche		M.D. 200
8. a. Name of physician who p 8. b. Physician's signature	provided RV-486	Mitche	Q Reides,	M.D. 200
8. a. Name of physician who p 8. b. Physician's signature Send completed forms to:	provided RV-486	Middle te (e)	Q Reides,	M.D. 20.0
8. a. Name of physician who p 8. b. Physician's signature Send completed forms to:	Da State Medi	Middle te (e)	Q Reides,	M.D. 20.0

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

JUN 6 2016



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided	l:	Month	12, W	Year
2. Name of medical practice	or facility at which R	U-486 was provid	led:	
3. Address of medical practic	e or facility at which	RU-486 was prov	ided:	
3295 GAST N	vain St. (d)	umbus	09 48	43
4. Date post RU-486 complic				
5. Event(s) (Please check all t	hat apply):			
Incomplete abortion		eaction to RU-486	Patient hospital	ized
Patient received a transfusion	Severe bleeding			
Other serious event (specify)				
6. Duration of event:	Hours	2 Days		
7. Remarks: Inomplete	Medica obort	u menag	n surgurally	
8. a. Name of physician who	provided RU-486			
8. b. Physician's signature		te 5/25/10		D./D.O
Send completed forms to:	State Medi	cal Board of Ohio		
	Legal Department		MED	ICAL BOARD
	30 E. Broad St., 3 <sup>rd</sup>		MED	ICAL BOARD
	Columbus, OH 43	215-6127	N	IAY 2 7 2016

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



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	Month Day	2016 Year
2. Name of medical practice or facility at wh Planned Parenthood		
3. Address of medical practice or facility at w 25350 Rock Bedford Hei	hich RU-486 was provided: side Road ints OH 44146	
4. Date post RU-486 complication began:	0/16/16	
5. Event(s) (Please check all that apply):		
✓Incomplete abortionAdv	erse reaction to RU-486 Patient hospitalized	
Patient received a transfusion Severe bleed	ing.	
Other serious event (specify)		
6. Duration of event: Hours	19_Days	
7. Remarks: Aspiration following in	edication abortion	7
8. a. Name of physician who provided RU-4	86 Timothy S. Kra	ess, ms
	un S Kungoyo	
	Date 9/15/16	
Send completed forms to:  Legal Departm 30 E., Broad St. Columbus, OH	, 3 <sup>rd</sup> Floor MEDICAL BOA	RD



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	Month	Day	79/6 Year
2. Name of medical practice or facility at wh	nich RU-486 was provide Vomen Ol		
3. Address of medical practice or facility at which was a support of the support		led:	
5. Event(s) (Please check all that apply):	M	EDICAL BO	ARD
Incomplete abortion Adv	verse reaction to RU-486 _	Patient hospital	16 lized
Patient received a transfusion Severe bleed Other serious event (specify)	ding		
6. Duration of event: Hours	Days		
7. Remarks: Ot culled lu	Ill Heady	other 1	mile Im iso
7. Remarks: At culled a le US should saw a Receled to Lave Sand	allowet !	thruft	Amilles Sont MISO
8. a. Name of physician who provided RU-A	186 U.M. 13	uskins	7)
8. b. Physician's signature	#	124/11	100
	Date —	92111	

Legal Department

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127



(Required pursuant to R.C. 2919.123)

L. Date RU-486 was provided:	The month	Day Day	1016 Year
2. Name of medical practice or facility at which RU-2  Planned Parenth 100 C	86 was provided:	argical	2
3. Address of medical practice or facility at which RU 3255 E. Main St Mu			13
4. Date post RU-486 complication began:	17/16		
5. Event(s) (Please check all that apply):  Incomplete abortion  Adverse reaction	ion to RU-486 P	atient hospitalized	
Patient received a transfusion Severe bleeding			ICAL BOARD UN 13 2016
Other serious event (specify)		J	
6. Duration of event: 24 Hours	Days		
7. Remarks: m complete expulsion à severe fibrid utenus	of POC d	ue to	
8. a. Name of physician who provided RU-486 8. b. Physician's signature  Date		Cotheri M.D./	re Romanus
Send completed forms to: State Medical	Board of Ohio		
Legal Department			
30 E. Broad St., 3 <sup>rd</sup> Flo Columbus, OH 43215			



(Required pursuant to R.C. 2919.123)

. Date RU-486 was provided:	Jure	10	2016
	Month	Day	Year
2. Name of medical practice or facility a	which RU-486 was provide	d: varica	Center
3. Address of medical practice or facility  395 F. Main			13213
4. Date post RU-486 complication began	: 6/15/16		
5. Event(s) (Please check all that apply):	_Adverse reaction to RU-486 _	Patient hospital	ized
Patient received a transfusion Severe	bleeding		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks: faled Medical	on abortion		
8. a. Name of physician who provided	RU-486		Zom Anos
8. b. Physician's signature	0	0/15/14	0/00
Send completed forms to: St	ate Medical Board of Ohio		
Legal Dep	artment		MEDICAL BOARI
30 E. Broa	ad St., 3 <sup>rd</sup> Floor		
Columbus	s, OH 43215-6127		JUN 1 7 2016



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

. Date RU-486 was provided:	06	17	16
	Month	Day	Year
. Name of medical practice or facility at w	hich RU-486 was provid	ed:	
. Address of medical practice or facility at 12000 Shaker Blvd. (	which RU-486 was prov	ided: 44120	
. Date post RU-486 complication began:	07/05/16		
Patient received a transfusion Severe blee Other serious event (specify)	dverse reaction to RU-486 eding	Patient hospitali.	zed
6. Duration of event: 2 Hours	Days		
7. Remarks: Abortion completed surgi	cally.		
8. a. Name of physician who provided RU- 8. b. Physician's signature	-486 Miles	1 Cide	)n.b.
Send completed forms to: State  Legal Depart  30 E. Broad			

Columbus, OH 43215-6127

MEDICAL BOARD

JUL 12 2016

Prescribed: 5/--/2021, Rev. 12/13/12



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	06	25	16
	Month	Day	Year
2. Name of medical practice or facility at w Planned Parent hood	Southwest	ded: - Ohio K	legion
3. Address of medical practice or facility at 2314 Auburn Aug. Ghuhnat: of 452		vided:	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):Incomplete abortionA	dverse reaction to RU-486	Patient hospital	MEDICAL BOA
Patient received a transfusion Severe ble  Other serious event (specify) Fa		ca lated	. O COCUCU
6. Duration of event: Hours			
7. Remarks:			
8. a. Name of physician who provided RU	-486 _ Sho	iron livel	
8. b. Physician's signature	Date P	12/16 M.	0./0.0
Send completed forms to: State  / Legal Depart 30 E. Broad			



(Required pursuant to R.C. 2919.123)

L. Date RU-486 was provide	d:	Month	Day	, 2019 Year
2. Name of medical practice	e or facility at which	RU-486 was provi	ded:	
3. Address of medical practi				13
3255 East Na	in St. C	dunby,	OH 430	13
4. Date post RU-486 compli				
5. Event(s) (Please check al	that apply):			
National Incomplete abortion	Adverse	e reaction to RU-486	Patient hospit	talized
Other serious event (specify  6. Duration of event:		Days		
7. Remarks: Failed med	lical above him con	phted surgice	tely	
8. a. Name of physician w	no provided RU-486	Roma	u03	
8. a. Name of physician wl 8. b. Physician's signature	me			4.D. / D.O
	me	7/10	long	A.D. / D.O
8. b. Physician's signature	me	pate 7/15 dical Board of Ohi	12014	AD./D.O  MEDICAL BOARD



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

. Date RU-486 was provided:	07	06	16
	Month	Day	Year
Name of medical practice or facility at the pre-lem	which RU-486 was prov	rided:	
. Address of medical practice or facility a	t which RU-486 was pro	ovided:	
12000 Shaker Blud.			
1. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
	Adverse reaction to RU-486	Patient hospitali	zed
Patient received a transfusion Severe b	leeding		
Other serious event (specify)			
6. Duration of event: 2 Hours	Days		
7. Remarks:			
	.,,,	1 0	
8. a. Name of physician who provided R	U-486 Moh	ammed 1620	e, M.V.
8. b. Physician's signature	Date J	31/6 MI	y 00_
Send completed forms to: Stat	te Medical Board of Oh	io	
Legal Depa	rtment		
	St., 3 <sup>rd</sup> Floor		
	OH 43215-6127		

MEDICAL BOARD

SEP 6 2016



(Required pursuant to R.C. 2919.123)

	L.			
. Date RU-486 was provided:	7	-	21	2016
	Month	) Da	y :	Year
Name of medical practice or facility at which Planned Parenthood	RU-486 was provide of Greater	d: - <i>OV</i>	130	
Address of medical practice or facility at which 25350 Rocks.  Bedford Heigh	h RU-486 was provided Road	ed: 1414(	0	
I. Date post RU-486 complication began:	lulio			
5. Event(s) (Please check all that apply):	e reaction to RU-486	Patien	. hospitalized	
Other serious event (specify)  6. Duřation of event: Hours				
7. Remarks: Aspiration for following me	non-viable dication ab	ges	tation	
8. a. Name of physician who provided RU-486 8. b. Physician's signature			SK	ress, MD
Send completed forms to:  State Me  Legal Departmer  30 E. Broad St., 3  Columbus, OH 4	3 <sup>rd</sup> Floor		M	EDICAL BOARI SEP 1 <b>9</b> 2016
Prescribed: 5/-/2011, Rev. 12/13/12			1-1-	



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	27	30	16
	Month	Day	Year
2. Name of medical practice or facility at w	vhich RU-486 was p		
3. Address of medical practice or facility at	which RU-486 was	provided:	
12000 Shaker Blud. (	Leveland	44120	
4. Date post RU-486 complication began:			
5. Event(s) (Please check/all that apply):	•		
Incomplete abortionAc	dverse reaction to RU-4	186 Patient hospitali	zed
	- #1		
Patient received a transfusion Severe blee	eaing		
Other serious event (specify)			And the second second
6. Duration of event:/ Hours	Days		
7. Remarks:			
8. a. Name of physician who provided RU	486 M	Itabell Reide	r, M.D.
8. b. Physician's signature	Date 8	/20/16 MD	// 00
Send completed forms to: State	Medical Board of O	hio	

Legal Department

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127

MEDICAL BOARD



(Required pursuant to R.C. 2919.123)

1. Date RU-486 v	as provided:	8		5 2016
		Month'	\	ay Year
	cal practice or facility at which ed Perenthood		1	110
3. Address of med	dical practice or facility at white 25350 Rocks Bedford Heigh	ide kozo		
4. Date post RU-4	86 complication began:	10		
✓Incomplete abo	e check all that apply):	e reaction to RU-486	Patien	t hospitalized
Other serious ev				
6. Duration of ev 7. Remarks:	Aspiration for following med		wegn	oncy
	following med	dication ab	prtie	n.
8. a. Name of ph 8. b. Physician's	Brocare	Tin Sku ate 9/15/1	m	S. Kress, MO
Send completed	forms to: State Med Legal Departmen 30 E., Broad St., 3 Columbus, OH 4	<sup>rd</sup> Floor		MEDICAL BOARD SEP 1 9 2016
Prescribed: 5/-/2011, Re	v. 12/13/12		1	



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

Date RU-486 was provided:	8	11	16
	Month	Day	Year
2. Name of medical practice or facility a Planned Parenthood	South We	ded: st Ohio	
3. Address of medical practice or facility	at which RU-486 was pro	vided:	
2314 Auburn Au	e. Cincimo	st: of	45219
4. Date post RU-486 complication began			
5. Event(s) (Please check all that apply):			
Incomplete abortion	_ Adverse reaction to RU-486	Patient hospita	alized
Patient received a transfusion Severe	bleeding		
Other serious event (specify) Failed	Abortion co	meleted	Serjically.
6. Duration of event: Hours	s Days		
7. Remarks:			
``	2	1/2/11	
8. a. Name of physician who provided	RU-486 Dr	. ICC139.	
8. b. Physician's signature	Date	10/4/16	LD / D.O
Send completed forms to: St	ate Medical Board of Ohio	3	
Legal Dep	partment		MEDICAL BOA
30 E. Bro	ad St., 3 <sup>rd</sup> Floor		

Columbus, OH 43215-6127

OCT 11 2016



#### MEDICAL BOARD

(Required pursuant to R.C. 2919.123)

SEP 23 2016

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	8	16	16
	Month	Day	Year
2. Name of medical practice or facility at which Planned Parenthood So			fion
3. Address of medical practice or facility at whice 2314 Auburn Avy.			45219
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):  Incomplete abortion Adverse  Patient received a transfusion Severe bleeding  Other serious event (specify)	e reaction to RU-486	Patient hospitali	zed
and deliber agent fall agent)			
6. Duration of event: Hours	Days		

Legal Department 30 E. Broad St., 3<sup>rd</sup> Floor Columbus, OH 43215-6127