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 (Month) 16 (Day) 2016 (Year)

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

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

MEDICAL BOARD
AUG 29 2016

4. Date post RU-486 complication began: 8/24/2016

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) Failed medical abortion

6. Duration of event: 2 Hours _____ Days

7. Remarks:
Surgical completion of abortion

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

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

Date 8/24/2016

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: Aug (Month) 17 (Day) 2016 (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 Road
Bedford Heights OH 44146

4. Date post RU-486 complication began:
8/26/16

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 9 Days

7. Remarks: Aspiration for slowly declining hCG levels following medication abortion.

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

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

Date 9/15/16

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 2016

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: AUG (Month) 19 (Day) 2016 (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 Road
Bedford Heights OH 44146

4. Date post RU-486 complication began: 9/2/16

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: Patient did very well post aspiration.

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

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

Date 10/21/16

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

MEDICAL BOARD
OCT 31 2016

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: 8 (Month) 19 (Day) 2016 (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 Road
Bedford Heights OH 44146

4. Date post RU-486 complication began:
8/24/16

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 5 Days

7. Remarks: Aspiration for on-going pregnancy following medication abortion

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

8. b. Physician's signature Timothy S. Kress MD/DO

Date 9/15/16

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 2016

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: 08 (Month) 24 (Day) 16 (Year)

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

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

4. Date post RU-486 complication began:
9/6/16

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: failed medication abortion completed surgical

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

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

Date 9/14/2016

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 2016

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: Aug (Month) 26 (Day) 2016 (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 Road
Bedford Heights OH 44146

4. Date post RU-486 complication began:
8/31/16

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 5 Days

7. Remarks: Aspiration for non-viable gestation following medication abortion.

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

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

Date 9/15/16

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 2016

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: Sept (Month) 8 (Day) 2016 (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 Road
Bedford Heights OH 44146

4. Date post RU-486 complication began:
9/21/16

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: Medication abortion per FDA regimen on 9/8/16 Pt diagnosed with on-going pregnancy + treated with aspiration on 9/21/19. Pt did very well post op.

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

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

Date 10/21/16

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

MEDICAL BOARD
OCT 31 2016

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: November 22 2016
   Month Day Year

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

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

4. Date post RU-486 complication began:
   12/6/16

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) Failed Abortion

6. Duration of event: _____ Hours ~~14~~ 21 Days

7. Remarks:
   FDA medication abortion @ 9w3d failed. D&C for ongoing IUP on 12/13/16.

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

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

   Date 12/13/16

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

MEDICAL BOARD
DEC 16 2016

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) 29 (Day) 2016 (Year)

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

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

4. Date post RU-486 complication began: 1/3/17

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) Failed Medication Abortion

6. Duration of event: _____ Hours 45 Days

7. Remarks: Failed Medication Abortion with D&C procedure

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

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

Date 1/17/17

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: 12 (Month) 2 (Day) 16 (Year)

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

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

4. Date post RU-486 complication began:
12/8/16

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: completed surgically

8. a. Name of physician who provided RU-486 D. Kelsy

8. b. Physician's signature [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
DEC 27 2016

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) 6 (Day) 2016 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood East Columbus Surgical

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: 1/5/17

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) Failed Medication Abortion

6. Duration of event: _____ Hours 35 Days

7. Remarks: Failed Medication Abortion with D&C procedure

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

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

Date 1/17/17

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

MEDICAL BOARD
JAN 19 2017

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) 13 (Day) 16 (Year)

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

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:
12/21/16

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) Failed Medication Abortion

6. Duration of event: _____ Hours 9 Days

7. Remarks:
D&C performed uncomplicated

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

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

Date 12/29/16

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: 12 / 14 / 16
   Month / Day / 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, Ohio 44146

4. Date post RU-486 complication began: 12-22-16

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: 1 Hours _____ Days

7. Remarks: Pt underwent FDA protocol medication abortion regimen. At follow up ultrasound visit, a continuing IUP was detected. Pt was aspirated at that visit and has been doing well since then.

8. a. Name of physician who provided RU-486 TIMOTHY KROSS MD

8. b. Physician's signature Timothy Kross MD/DO

   Date 1/27/17

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: 12 (Month) 15 (Day) 16 (Year)

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

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

4. Date post RU-486 complication began: 1/3/17

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: D&C done without issue

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

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

Date 1/4/17

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

JAN 09 '17

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: December (Month) 15 (Day) 2016 (Year)

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

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

4. Date post RU-486 complication began: 12/22/16

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

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

___ Patient received a transfusion ___ Severe bleeding

MEDICAL BOARD
JAN 10 2017

X Other serious event (specify) Failed Medication Abortion

6. Duration of event: _____ Hours 15 Days

7. Remarks:
failed medication abortion resolved with D&C - uncomplicated

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

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

Date 1/9/2017

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: 12 (Month) 15 (Day) 16 (Year)

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

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

4. Date post RU-486 complication began: 1/3/17

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:
Completed w/ D+C without issue

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

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

Date 1/4/17

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

Prescribed: S/--/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: 9 (Month) 9 (Day) 16 (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:
9/15/16

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 (plus time in ER for transfusion)

7. Remarks:

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

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

Date 10/4/16

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

MEDICAL BOARD
OCT 11 2016

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: Sept (Month) 15 (Day) 2016 (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 Road
Bedford Heights OH 44146

4. Date post RU-486 complication began: 9/29/16

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

7. Remarks: Medication abortion per FDA regimen on 9/15/16. Pt. diagnosed with ongoing pregnancy and treated with aspiration on 10/13/16. Pt. did very well post-op.

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

8. b. Physician's signature Timothy Kress MD/DO

Date 11/10/16

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

MEDICAL BOARD
NOV 15 2016

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: September 27 2016
   Month Day Year

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

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

4. Date post RU-486 complication began: 10/5/16

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
OCT 17 2016

6. Duration of event: _____ Hours _____ Days

7. Remarks:
   incomplete MTB required suction procedure

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

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

   Date 10/12/16

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: 10 (Month) 4 (Day) 16 (Year)

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

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

4. Date post RU-486 complication began:
10/22/16

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) Failed medication Abortion

6. Duration of event: 2 Hours _____ Days when pt returned for surgical completion

7. Remarks:

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

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

Date 12/6/16

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

Prescribed: S/--/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) 4 (Day) 16 (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.

4. Date post RU-486 complication began:
10/16/16

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:
completed surgically without issue

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

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

Date 10/25/16

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: Oct (Month) 5 (Day) 2016 (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 Road
Bedford Heights OH 44146

4. Date post RU-486 complication began:
10/21/16

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: Medication abortion per FDA regimen on 10/5/16. Pt diagnosed with on-going pregnancy and treated with aspiration on 10/21/16. Pt did very well post op.

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

8. b. Physician's signature Timothy Kress MD/DO

Date 11/10/16

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

MEDICAL BOARD
NOV 15 2016

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) 6 (Day) 2016 (Year)

2. Name of medical practice or facility at which RU-486 was provided: NORTHEAST OHIO WOMENS CENTER LLC 2127 STATE RD ~~CUYAHOGA FALLS, OH 44223~~

NORTHEAST OHIO WOMENS CENTER LLC 2127 STATE RD CUYAHOGA FALLS, OH 44223

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

4. Date post RU-486 complication began: 10/30/16

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: 1 Hours _____ Days

7. Remarks: Pt had D&C at our facility on 10/31/16 without complication.

8. a. Name of physician who provided RU-486: David M. Brikins, MD

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

Date 4/7/16

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

MEDICAL BOARD
NOV 10 2016

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: Oct (Month) 7 (Day) 2016 (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 Road
Bedford Heights OH 44146

4. Date post RU-486 complication began:
10/18/16

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 3 Days

7. Remarks: Patient did very well post aspiration.

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

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

Date 11/10/16

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: Oct (Month) 14 (Day) 2016 (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 Road
Bedford Heights, OH 44146

4. Date post RU-486 complication began:
11/10/16

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
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6. Duration of event: _____ Hours _____ Days

7. Remarks: Pt. treated with surgical aspiration with no further complications. Pt did well post-op.

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

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

Date 12/23/16

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: 10 (Month) 25 (Day) 16 (Year)

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

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

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

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) Failed Medication Abortion

6. Duration of event: 3 Hours _____ Days

7. Remarks:
completed surgically without issue

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

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

Date 12/6/16

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: 10/27/16
   Month Day 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 Road
   Bedford Heights, OH 44146

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

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: Surgical aspiration was done with no further complications. Pt. did well post op.

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

8. b. Physician's signature Timothy S Kress MD/DO

   Date 12/28/16

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

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JAN 09 2017

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) 28 (Day) 2016 (Year)

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

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

4. Date post RU-486 complication began: 11/8/16

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) Failed Medication Abortion

6. Duration of event: _____ Hours 11 Days

7. Remarks:

8. a. Name of physician who provided RU-486 Michelle Isley

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

Date 11/18/16

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

MEDICAL BOARD
NOV 21 2016

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: November (Month) 3 (Day) 2016 (Year)

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

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

4. Date post RU-486 complication began: 11/10/16

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 19 Days

7. Remarks:

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

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

Date 11/22/16

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

MEDICAL BOARD
NOV 25 2016

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 / 9 / 16
   Month Day 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, Ohio 44146

4. Date post RU-486 complication began:
   11/17/16

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: Surgical aspiration performed with no further complications. Pt did well post-op.

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 12/28/16

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

MEDICAL BOARD
JAN 09 2017

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: November (Month) 17 (Day) 2016 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood – East Surgical

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:
12/15/16

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) Failed Medication Abortion

6. Duration of event: _____ Hours 33 Days

7. Remarks:
D&C performed - uncomplicated.

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

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

Date 12/29/16

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

MEDICAL BOARD
JAN 03 2017

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) 22 (Day) 16 (Year)

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

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

4. Date post RU-486 complication began:
12/3/16

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:
D&C done without incident.

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

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

Date 12/7/16

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

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