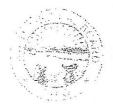
MEDICAL BOARD



Education Foundation



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-485

1. Date RU-486 was provid	led:	1	3	17
		Month	Day	Year
2. Name of medical practic	/1	ch RU-486 was provid	ed:	
3. Address of medical pract	ice or facility at wh	ich RU-486 was provi	ded:	
2314 Aubur	· Au. a	ina, of	45219	
4. Date post RU-486 compli	cation began:	1/12/17		
5. Event(s) (Please check all	that apply):		***	
Incomplete abortion	Advers	se reaction to RU-486 _	Patient hospitalized	ſ
Patient received a transfusio	n Severe bleeding	3		
Other serious event (specify)	infec	tion		
6. Duration of event:	Hours _/ <u>/</u> /	Days		
7. Remarks: faspondes c	oili to	antibistic	ſ	
	٠,			
3. a. Name of physician who	provided RU-486		DI Piu	El.
3. b. Physician's signature			(M.D.)	20
and completed forms		te —	()C	
end completed forms to:		ical Board of Ohio)	
	Legal Department		The same of the sa	
	30 E. Broad St., 3 rd Columbus, OH 432		Colu Edu	Imbus Right to L

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



(Required pursuant to R.C. 2919.123)

Date RU-486 was provided:		Month	Day	Year	
	uu tuhiah D	11-486 was provi	ded: .		
Name of medical practice or to Parenth	1000 ta	J July	CVCT		_
. Address of medical practice of Bast Mair	r facility at which	RU-486 was pro WMDUS,	vided: ONIO 43	5213	
1. Date post RU-486 complicati	on began:	23/17			
5. Event(s) (Please check all that	at apply): Adverse	e reaction to RU-486	Patient hospi	talized	,
	a blooding				
Patient received a transfusion Other serious event (specify)					
Other serious event (specify) 6. Duration of event:	Hours L	₽ Days			
	Hours L	P_Days			
Other serious event (specify) 6. Duration of event:	Hours IL	P Days Pledicat	erine Rov		



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

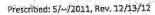
. Date RU-486 was provided:	Month	13 Day	Year
. Name of medical practice or facility at Planned Parenthood	which RU-486 was pro cf Greater	vided: Ohio	
3. Address of medical practice or facility: 25350 Rockside Rd.	at which RU-486 was pr Bedford H	ovided: leights, Ohio	44146
4. Date post RU-486 complication began	2/3/17		
5. Event(s) (Please check all that apply):	Adverse reaction to RU-48	6 Patient hospitalize	d
Patient received a transfusion Severe			
6. Duration of event: Hours	<u>S</u> Days		
7. Remarks: Pt. Nuc. medica confirmed completes a of increased bleeding pt. It well post - of 8. a. Name of physician who provided	bortum. Su ond aspiras	by perform	red on 2/8/17.
8. b. Physician's signature	Date 3	5 puringo	/50
	ate Medical Board of Co	hio	

30 E., Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

MAR 0 6 2017





(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

Date RU-486 was provided:	- 1	13	2017
and the second second	Month	Day	Year
Name of medical practice or facility at w Planned Parenthood	which RU-486 was prov f Greater	vided: Ohio	
3. Address of medical practice or facility at 25350 Rockside Rd	which RU-486 was pr Bestord H	ovided: eights, Ohic	44146
4. Date post RU-486 complication began:	2/3/17	¥	
5. Event(s) (Please check all that apply):	Adverse reaction to RU-486	5 Patient hospitaliz	ed
Patient received a transfusion Severe ble	# #		
6. Duration of event: Hours	5 Days		
7. Remarks: Pt. Nuc. Mccicat confirmed congrete ab of increased bleeding Pt. Lis well post-op 8. a. Name of physician who provided Ri	ond aspirad	in perfor	patient comple ned on 2/8/17
	U-486 7 Kres	5	<u> </u>

Legal Department

30 E., Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

MAR 0 6 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)

1. Date RU-486 was provide	ed:	CI	17	2017
		Month	. Day	Year
2. Name of medical practice Planned Paren				
3. Address of medical practi 3255 East Ma	ce or facility at whice	h RU-486 was pr	ovided: S, Ohio 4	13213
4. Date post RU-486 compli	cation began:	124/17		
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)	Failed Mt	edication	Abortion	\cap
6. Duration of event:	Hours	Days	1	
7. Remarks: D+C af	ter failed	medica	tion abort	ion
8. a. Name of physician who	provided RU-486	Cathe	rine Rom	ianos
8. b. Physician's signature	. (12:5		/D.O
	Da	te	.)	3017
Send completed forms to:	State Medi	cal Board of Ohi	0	
	Legal Department			1
	30 E. Broad St., 3 rd	Floor		,
	Columbus, OH 43	215-6127	MEDICAL BO	ARTA
			fifth a stage	Militer State of the Contract



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

L. Date RU-486 was provided:	1	19	2017
	Month	. Day	Year
2. Name of medical practice or facility a Planned Parenthood	at which RU-486 was produced - East Scu	ovided:	
3. Address of medical practice or facility 3255 East Main St.	at which RU-486 was p , Columbus	rovided: , Chic 430	213
4. Date post RU-486 complication bega	n: 1/30/17		
5. Event(s) (Please check all that apply)	:		
\(\sum_{\text{Incomplete abortion}}\)	Adverse reaction to RU-48	Patient hospitali	zed
Patient received a transfusion Severe	e bleeding		
Other serious event (specify)			
6. Duration of event: Hour	rs Days		
7. Remarks: Incomplete MAB Ha	luining 10 \$ C		
8. a. Name of physician who provided	RU-486 Cath	evine Roma	nas
8. b. Physician's signature	Date —	S 9/0	B:/0.0
Send completed forms to:	state Medical Board of C)hio	
	epartment		
	oad St., 3 rd Floor	PACTE	TAL BOARD
Columb	us, OH 43215-6127	18250 a. + 25	ALDIAKI)
		FE	B 2 2 2017

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

(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided	d:	22	0/	17
2. Name of medical practice	or facility at which		Day led:	Year
3. Address of medical practice 12000 Sucker 4. Date post RU-486 complice 5. Event(s) (Please check all sections)	the or facility at which $\frac{6 vd}{c}$ (sation began: $\frac{6 \sqrt{2}\sqrt{17}}{\sqrt{2}\sqrt{17}}$	n RU-486 was prov		
Incomplete abortion Patient received a transfusion Other serious event (specify)	Severe bleeding		Patient hospitalized	d
6. Duration of event:	Hours	Days		
8. a. Name of physician who 8. b. Physician's signature	111	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 17	M.D.
Send completed forms to:		ical Board of Ohio	MEDICAL I	



(Required pursuant to R.C. 2919.123)

. Date RU-486 was provided:	. 2	6	2017
	Month	Day	Year
2. Name of medical practice or facility at which Planned Parenthood - Eas	RU-486 was prov St SUrgici	ided:	
3. Address of medical practice or facility at which 3255 East Main St., Coll	h RU-486 was pro JIMDUS ; ()	wided: thic 4321	3
4. Date post RU-486 complication began: 2	14/17		
5. Event(s) (Please check all that apply):Incomplete abortionAdverse	reaction to RU-486	Patient hospitalized	1
Patient received a transfusion Severe bleeding		,	is.
X Other serious event (specify) Failed Ma	edication	Abortice)
6. Duration of event: Hours	Days		
7. Remarks: Failed Medication requiring surgice	Abortic	'n	
8. a. Name of physician who provided RU-486 8. b. Physician's signature	ate	Ponco De 1/21/	ne 10.0
Send completed forms to: State Med Legal Department 30 E. Broad St., 3' Columbus, OH 43	^d Floor	MEDICAL	80ARD 2 2017

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

. Date RU-486 was provided:	az	14	17
	Month	Day	Year
2. Name of medical practice or facility at	t which RU-486 was pr	rovided:	
3. Address of medical practice or facility	at which RU-486 was p	provided:	
12000 Shoker Bl	vd. Cleve	44120	
4. Date post RU-486 complication began	03/15/17		
5. Event(s) (Please check all that apply):	/ /		
Incomplete abortion	Adverse reaction to RU-4	86 Patient hospitaliz	ed
The meaning of the second of t			
Patient received a transfusion Severe b	bleeding		
	8		
Other serious event (specify)			8
6. Duration of event: Hours	Days		
o. Bulation of events			
7. Remarks:			
		1/ 1 :/	. // \
8. a. Name of physician who provided F	RU-486 Mon	Nique Katsuk	V.V.
8. b. Physician's signature	ryunter	MO	400
	Date 3/28	117	
Send completed forms to: Sta	ate Medical Board of O	hio	
icha completea forms to.			

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

APR 0 3 2017



Greater Columbias Right to Life

(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided	d:	2	25	1-7
*		Month	Day	Year
2. Name of medical practice	or facility at which R		ed:	
3. Address of medical practice 3255 East			1	
4. Date post RU-486 complice 3/2/1 5. Event(s) (Please check all 1				
Incomplete abortion	Adverse r	eaction to RU-486	Patient hospitalized	
Patient received a transfusion	Severe bleeding		er	
Other serious event (specify)				
6. Duration of event:	Hours	Days		
7. Remarks: Med Af	3 incomplete	e Misc	repeat dos	ng.
8. a. Name of physician who	provided RU-486	Romani	05 2 MO/0 3/7/	0
Send completed forms to:	State Medic Legal Department 30 E. Broad St., 3 rd Columbus, OH 432		MEDICAL BO	
			MAR 1 7 201	7

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provide	ed:	0.3	24	17
		Month	Day	Year
2. Name of medical practice	e or facility at which	RU-486 was provi	ded:	
3. Address of medical practic	ce or facility at which	th RU-486 was prov	vided:	
4. Date post RU-486 complic	cation began: 3/a	4/17		
5. Event(s) (Please check all				:
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:	4.			
8. a. Name of physician who	provided RV-486	- Mitchel	Il Rider, 1	1. D
8. b. Physician's signature) Da) te 3/	(31/17 MD)D	.0
Send completed forms to:	State Medi	cal Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd	Floor		
	Columbus, OH 432	215-6127	MEDICALE	BOARD

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

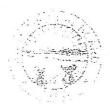
APR 03 2017

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provide	ed:	OS.	24	17
		Month	Day	Year
2. Name of medical practice	e or facility at which	ı RU-486 was provi	ded:	
3. Address of medical pract	ice or facility at whi	ch RU-486 was pro	vided:	
12000 Shakes				
4. Date post RU-486 compl 3/10/17				
5. Event(s) (Please check al	I that apply):	1		
/Incomplete abortion	Advers	e reaction to RU-486	Patient hospitaliz	red .
Patient received a transfusion	on Severe bleeding	3		
Other serious event (specify	′)			
6. Duration of event:	Hours	Days		
7. Remarks:				1
			100 0.	7 (1)
8. a. Name of physician wh	o provided RU-486	4 NTS		ler, M.D.
8. b. Physician's signature	·//	ate	3/11/17	/00
Send completed forms to:	State Me	dical Board of Ohio		
	Legal Departmer	it		
	30 E. Broad St., 3	rd Floor		-CADA
	Columbus, OH 4	3215-6127	ME	DICAL BOARD
				MAR 1 5 2017

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



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	2	25	17
	Month	Day	Year
2. Name of medical practice or facility a Planned Parenthood		vided:	
3. Address of medical practice or facility 2314 Auburn Au.			
4. Date post RU-486 complication began	n: 		
5. Event(s) (Please check all that apply):			
Incomplete abortion	_Adverse reaction to RU-486	Patient hospitalized	d
Patient received a transfusion Severe	bleeding		
Other serious event (specify)	led Abstion		
6. Duration of event: 2 Hours	Days		
7. Remarks: Campleted Surgica	lly without	in cident.	
8. a. Name of physician who provided R	U-488	Dr. Kalsy	
8. b. Physician's signature		1/2 (MD)/	D.O
Send completed forms to: Sta	te Medical Board of Ohio)	
Legal Depa		a punguage of a second	3 3 D ? :
	d St., 3 rd Floor	MEDICAL RE	19/K/
Columbus,	OH 43215-6127	MAR 24 71	17



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provide	d: .	2	. 28	j	1
N N		Month	Ďay	. :	Year
2. Name of medical practice Planned Paren	or facility at which RU thood cf G	-486 was prov	ded: Ohio		
3. Address of medical practice 25350 Rocksid		U-486 was pro 1 for 2 He	vided:	thio	44146
4. Date post RU-486 complic	action began: 3/1	1117			
5. Event(s) (Please check all	that apply):			i.	
Incomplete abortion	Adverse rea	iction to RU-486	Patient hos	pitalized	
Patient received a transfusion Other serious event (specify)		tra			
Cother serious event (specify)					
6. Duration of event:	Hours	Days			
7. Remarks: Medicat increased bleed procedure was well past op	- C · -	nping-	nemato	metr	a. Pt di
8. a. Name of physician who	provided RU-486	Tiv	nothy s	3. Kre	35, W
8. b. Physician's signature	Trult	Z S K	ann	MD DI	_
	Date		. 4/14/1	A	
Send completed forms to:	Legal Department 30 E. Broad St., 3 rd F		0	MEDIC	CAL BOARD
4	Columbus, OH 4321	5-6127		Λ.Ρ	R 2 0 2017

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



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	2	. 28	2017
	Month	Ďay	Year
2. Name of medical practice or facility at which Planned Parenthood of	RU-486 was prov Greater	ided: Ohio	and the second s
3. Address of medical practice or facility at which 25350 Rockside Rd.	th RU-486 was pro Bedford Ho	ovided: eights, Ohio	44146
4. Date post RU-486 complication began: 4	119/17		
5. Event(s) (Please check all that apply):	e reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe bleeding Other serious event (specify)			
6. Duration of event: Hours			
7. Remarks: Med ab per FDA rec post-aportion follow up on 4 in 1666. Ultrasound on 4/20 Die was performed on 4/20	5/17 Showe	& continued	pregnance
8. a. Name of physician who provided RU-486 8. b. Physician's signature		15/9/12	
Send completed forms to: State Me	dical Board of Ohi	0	
Legal Departmen			
30 E. Broad St., 3	ro		

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



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

 Date RU-486 was provided: 	2	28	17
	Month	Day	Year
2. Name of medical practice or facility at which Planned Parenthood	th RU-486 was provi	ded:	
3. Address of medical practice or facility at wh 2314 Auburn Au. C			
4. Date post RU-486 complication began:	14/17		
5. Event(s) (Please check all that apply): Adver Patient received a transfusion Severe bleeding	se reaction to RU-486	Patient hospitalize	ed
Other serious event (specify)			
Other serious event (specify) 6. Duration of event: Hours			
	Days	L,	

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

MAR 3 1 2017



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

L. Date RU-486 was provided:		3	Day	2017 Year
		onth'		reat
Name of medical practice or facility a Planned Parenthood	of Gre	aver	Ohio	
3. Address of medical practice or facility 25350 Rockside Rd		86 was prov	vided: ights, Ohi	s ५५१५6
4. Date post RU-486 complication bega	m: 4/12/	17		
5. Event(s) (Please check all that apply)	. Adverse reaction	n to RU-486	Patient hospitali	ted
Patient received a transfusion Sever Other serious event (specify)				
6. Duration of event: 1 Hour				
7. Remarks: Med. ab. per F for scheduled following ultrasound. Results 5 performed on 4/13/17.	honed Co	entinu	ed pregna t-op.	ney OHE
8. a. Name of physician who provided		-		Kress, MO
8. b. Physician's signature	Date —	> K	E1/1815.) /BO
Legal De 30 E.,Bro	State Medical Br epartment oad St., 3 rd Floor	т	MEDICAL	BOARD
	oad St., 3 Floor us, OH 43215-6		MEDICAL MAY IT	

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

(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provide	ed:	23	07	17
		Month	Day	Year
2. Name of medical practice	e or facility at which R	U-486 was provid	ed:	
3. Address of medical practi	ce or facility at which	RU-486 was provi	ided:	
12000 Shaker				
4. Date post RU-486 compli	1			
5. Event(s) (Please check all	that apply):			
Incomplete abortion	Adverse re	eaction to RU-486	Patient hospitaliz	ed
Patient received a transfusio	n Severe bleeding			
Other serious event (specify)		•		
6. Duration of event: 2	Hours	_ Days		
7. Remarks:				
8. a. Name of physician who	^ /	Non	ique Katsin	K., M.D.
8. b. Physician's signature	Date	1/1/2014	MD 21/17	<u>/po</u>
Send completed forms to:	State Medica	al Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd F	loor		
	Columbus, OH 4323	* ALDIA	CALBOARD	
		W.	AR 24 2017	



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

. Date RU-486 was provided:	Mar	ch 11	2017	
	Month	Day !	Year	
2. Name of medical practice or facility at which Planned Parenthood of				
3. Address of medical practice or facility at whi 25350 Rockside Rd.		vided: ights, Ohic	5 44146	ò
4. Date post RU-486 complication began: 3	116/17			
5. Event(s) (Please check all that apply):				
Advers	e reaction to RU-486	Patient hospitalize	≥ d	
Patient received a transfusionSevere bleeding			8	
Other serious event (specify)				
6. Duration of event: Hours	Days			
7. Remarks: Persistent gestach MAS Follow-up visit or	mal sac	noted on u	Itrason	nd at
mas follow-up visit or	3/16/17. 5	actum proc	e du e do	ne
and pt. did well post				A
3. a. Name of physician who provided RU-486	- 1/	nothy 5.		<u>~></u>
3. b. Physician's signature	ai > M	WD (MD)	100	
s. b. Fitysician's signature	n i	FILL.		- [

APR 2 0 2017

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



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	3	11	17
	Month	Day	Year
2. Name of medical practice or facility at whice Planned Parenthood	h RU-486 was pro	vided:	
3. Address of medical practice or facility at wh 2314 Auburn Au. Co			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
		Patient hospitalize	d
Other serious event (specify)	5		
6. Duration of event: Hours	Days		
7. Remarks: Dy (don without	incindent		
8. a. Name of physician who provided RU-486 8. b. Physician's signature	3	Dr. 601 1/5/17	'D.O
Send completed forms to: State Med	dical Board of Ohio)	

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

APR 14 2017

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	Morch 16 2019
1 3/	Month Day Year
2. Name of medical practice or facility at which	
Northeast Chic V	Vomen's Center
3. Address of medical practice or facility at which	h RU-486 was provided:
2127 State 121	
Puyahaca Fall	Chie 44273
4. Date post RU 486 complication began:	
ellic/M	
5. Event(s) (Please check all that apply):	
ncomplete abortion Adverse	reaction to RU-486 Patient hospitalized
Patient received a transfusion Severe bleeding	
Other serious event (specify)	
6. Duration of event: Hours	Davs
7. Remarks: It had 0 + C	without complications
	3.11.11. =
8. a. Name of physician who provided RU-486	JIM, WIRSON, MIL
8. b. Physician's signature	USON, MD/DO
Da	5/18/12
Send completed forms to: State Medi	cal Board of Ohio
Legal Department	
30 E. Broad St., 3 ^{rc}	Floor
Columbus, OH 43	215-6127 MEDICAL BOARD

MAY 26 2017



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

Month 486 was provide reader (U-486 was provide L-486 was provide	Dhio	Year 44146
reader (U-486 was provi	Ohio ded:	44146
U-486 was provi 1 ford Hei	ded: ghts, Ohio	44146
aford Hei	ghts, Ohio	44146
	A CONTRACTOR OF A STATE OF	
ction to RU-486	Patient hospitalize	id
	الم	
Days		
is starte.	5 on 3/22	17. P+ did
egnany	. Surgical	abortion w
well p	ost-op	e de la companya de l La companya de la co
Tymo	thy S. Kr	ess, wo
	6(16(17	
	Days SS starte. C as Inst cgnany well p Twns S Ku	Days SS started on 3/22 C as instructed we regnancy surgical well post op Twothy S. Ko S. Kums GH16/17

30 E., Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOAR:

JUN 2 2 2017

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	11/11/6	22	2010
3/22/0	Month	Day	OC /V / Year
2. Name of medical practice or facility at which			i edi
			/_
Northeast Chi	(Women's	2 (PN)	
3. Address of medical practice or facility at wh	ich RU-486 was provided	d:	
21249 State RA		4.21.2	
Cayalogo Palls	Ohla	44223	>
4. Date post RU-486 complication began:		7 7	
4/28/19			
5. Event(s) (Please check all that apply):		**************************************	
V			
incomplete abortion Adver	se reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe bleeding	g		
	*		8
Other serious event (specify)			
-			
6. Duration of event: Hours	Days		
A			
7. Remarks: St had Da	e witho	ut Co	mplustin
8. a. Name of physician who provided RU-486	L. ann 1	Tunna	1/4
	Count A	JUHINA	117
8. b. Physician's signature	YIN	/ MD/	(DO // /// //)
D	ate 1	- Mig 1	40 7/24/1T
Send completed forms to: State Med	dical Board of Ohio		5
Legal Departmen			
30 E. Broad St., 3			
Columbus, OH 4		MEDIC	TAL ROLDIN
columbus, off 4	J213 012/	, á à.	Y 9 8 2015
		VIΔ	1 6 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1

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



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:		3	29	17
	Mo	nth	Day	Year
2. Name of medical practice or fa Planned Parenth	/1	was provided	d:	
3. Address of medical practice or	facility at which RU-48	6 was provide	ed:	
2314 Auburn /	tue. Cina,	ot 4	15219	and the second s
4. Date post RU-486 complication $4/18/1$				
5. Event(s) (Please check all that a	pply):		The second secon	
Incomplete abortion	Adverse reaction t	o RU-486	Patient hospitalized	emenyeme
Patient received a transfusion	Severe bleeding			
Other serious event (specify)				MEDICAL BOA
6. Duration of event: 2	Hours Days			MAY 1 2 2017
7. Remarks:				
				and the second s
3. a. Name of physician who provid	ded RU-486		D. Kelly	
B. b. Physician's signature	1120	lay	(MD/DO	
	Date	19/17		
end completed forms to:	State Medical Board	of Ohio		
Legal	Department			
	Broad St., 3 rd Floor			
Colun	nbus, OH 43215-6127			