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) 21 (Day) 17 (Year)

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

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: 9/25/17

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 _____ Days

7. Remarks:
uncomplicated D&C

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

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

Date 9/27/17

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

MEDICAL BOARD
SEP 28 2017

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

S e 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: 7 (Month) 28 (Day) 17 (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: 8/4/17

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:

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

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

Date 8/11/17

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

MEDICAL BOARD

AUG 16 2017

What didn't they tell you?
ThisClinicHurtsWomen.com

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) 16 (Day) 17 (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: 8/21/17

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 MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks: Dilation and suction - uncomplicated.

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

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

Date 8/22/17

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

MEDICAL BOARD
AUG 24 2017

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

What didn't they tell you?
ThisClinicHurtsWomen.com

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) 28 (Day) 17 (Year)

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

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: 9/7/17

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: _____ Hours _____ Days

7. Remarks:
uncomplicated suction procedure

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

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

Date 9/21/17

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

MEDICAL BOARD
SEP 28 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: 9 (Month) 15 (Day) 17 (Year)

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

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: 9/25/17 at follow up

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 MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks:

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

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

Date 10/4/17

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

MEDICAL BOARD

OCT 11 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

1. Date RU-486 was provided: 09 (Month) 18 (Day) 17 (Year)

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

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:
9/22/17

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 _____ Days

7. Remarks:
uncomplicated suction

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

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

Date 9/25/17

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

MEDICAL BOARD
SEP 28 2017

Prescribed: 5/-J20-1, Rev. 12/13/12

What didn't they tell you?
ThisClinicHurtsWomen.com

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) 25 (Day) 2017 (Year)

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

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:
10/3/17

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: _____ Hours _____ Days

7. Remarks: uncomplicated D&C.

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

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

Date 10/16/17

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

MEDICAL BOARD
OCT 23 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: Oct. (Month) 9 (Day) 2017 (Year)

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

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:
10/13/17

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 MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks:

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

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

Date 10/14/17

Send completed forms to:

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

MEDICAL BOARD
OCT 18 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

MEDICAL BOARD
NOV 03 2017

1. Date RU-486 was provided: 10 (Month) 11 (Day) 17 (Year)

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

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: 10/31/17

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 _____ Days

7. Remarks:
uncomplicated DC

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

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

Date 10/31/17

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: Oct (Month) 16 (Day) 2017 (Year)

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

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: 11/22/17

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 _____ Days

7. Remarks: uncomplicated D:C

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

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

Date 11/28/17

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

MEDICAL BOARD

NOV 30 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

1. Date RU-486 was provided: Oct (Month) 18 (Day) 2017 (Year)

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

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:
10/23/17

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 _____ Days

7. Remarks:
uncomplicated DC

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

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

Date 10/25/17

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

MEDICAL BOARD
OCT 30 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

1. Date RU-486 was provided: 10 (Month) 18 (Day) 17 (Year)

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

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: 10/25/17

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 _____ Days

7. Remarks: uncomplicated D&C

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

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

Date 11/2/17

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

MEDICAL BOARD
NOV 06 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: Nov (Month) 9 (Day) 2017 (Year)

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

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: 11/17/17

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 MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks: uncomplicated suction

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

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

Date 11/20/17

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

MEDICAL BOARD
NOV 24 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) 20 (Day) 17 (Year)

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

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: 11/30/17

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 MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks: uncomplicated D:C

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

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

Date 12/15/17

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

MEDICAL BOARD
DEC 18 2017

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

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 11 (Month) 17 (Day) 17 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Capital Care Network Toledo

3. Address of medical practice or facility at which RU-486 was provided:
1160 W Sylvania Toledo OH 43612

4. Date post RU-486 complication began: 12/19/17

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: _____ Hours 3 Days

7. Remarks: DIC on 12/22/17 no further complications

8. a. Name of physician who provided RU-486 L. Ann Nunnally

8. b. Physician's signature L. A. Nunnally MD M.D/D.O___

Date 12/27/17

Send completed forms to:

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

MEDICAL BOARD
JAN 17 2018

State Medical Board of Ohio

Report of RU-486 Event

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 11 (Month) 28 (Day) 2017 (Year)

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

Capital Care Network Toledo

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

1160 W Sylvania Ave Toledo, OH 43612

4. Date post RU-486 complication began: 11/6/18

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 __1__ Days

7. Remarks: D&C on 11/6/18 no further complication

8. a. Name of physician who provided RU-486 L. Ann Nynnally

8. b. Physician's signature L. A. Nynnally M.D/D.O

Date 1/9/18

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

JAN 22 2018

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 6 (Month) 16 (Day) 17 (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:
7/22/17

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:
Readmitted w/ D+C.

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

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

Date 8/3/17

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

MEDICAL BOARD
AUG 08 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: 8 (Month) 4 (Day) 17 (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:
8/18/17

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 performed

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

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

Date 8/18/17

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

MEDICAL BOARD
SEP 1 2017

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) 21 (Day) 17 (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:

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 med Abo

6. Duration of event: 1 (treatment) Hours _____ Days

7. Remarks:

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

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

Date 12/3/17

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

MEDICAL BOARD
OCT 06 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: 9 (Month) 20 (Day) 17 (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:
10/04/17

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) Failed medical Abortion

6. Duration of event: 2 Hours _____ Days

7. Remarks:
completed surgically w/o issue

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

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

Date 10/5/17

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

MEDICAL BOARD
OCT 12 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) 19 (Day) 17 (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: 12/1/17

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) continued pregnancy.

6. Duration of event: _____ Hours 2 Days

7. Remarks: pt. had termination completed surgically.

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

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

Date 12/6/17

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

MEDICAL BOARD
DEC 15 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) 15 (Day) 17 (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: 11/29/17

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) ongoing pregnancy

6. Duration of event: 1 Hours _____ Days

7. Remarks: completed surgically.

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

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

Date 12/11/17

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

MEDICAL BOARD
DEC 15 20[illegible]

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) 17 (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:
12/21/17

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:

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

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

Date 12/26/17

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

MEDICAL BOARD
JAN 09 2018

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

State Medical Board of Ohio

Report of RU-486 Event

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 09 (Month) 21 (Day) 17 (Year)

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

The Founder's Women's Health Center
1243 East Broad Street
Columbus, Ohio 43205

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

See above

4. Date post RU-486 complication began: 9-25-17 ; 10-12-17

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: 41 Hours 0 Days

7. Remarks: Multiple pregnancy, failed medical Suction aspiration treatment.

8. a. Name of physician who provided RU-486: DR Blank MD

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

Date 11-11-17

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 2017

State Medical Board of Ohio

Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 11 (Month) 25 (Day) 17 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Founder's Women's Health Center

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St. Columbus, Ohio 43205

4. Date post RU-486 complication began:
12.9.17

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:
Moderate tissue

8. a. Name of physician who provided RU-486 Harley Blank MD

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

Date 12.9.17

Send completed forms to:

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

MEDICAL BOARD
DEC 14 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

1. Date RU-486 was provided: 06 (Month) 15 (Day) 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 12000 Shaker Blvd. Cleveland 44120

4. Date post RU-486 complication began:

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

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

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Monique Katsuki, M.D.

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

Date 9/12/17

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

MEDICAL BOARD
SEP 14 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: 08 (Month) 16 (Day) 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 12000 Shaker Blvd. Cleveland 44120

4. Date post RU-486 complication began: 09/12/17

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: 4 Hours _____ Days

7. Remarks:

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

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

Date 9/16/17

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

MEDICAL BOARD
SEP 20 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

1. Date RU-486 was provided: 09 (Month) 22 (Day) 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 12000 Shaker Blvd. Clev. 44120

4. Date post RU-486 complication began: 10/06/17

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:

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

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

Date 10/20/17

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

MEDICAL BOARD
OCT 24 2017

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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) 10 (Day) 2017 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
12000 Shaker Blvd. Cleveland, Ohio 44120

4. Date post RU-486 complication began:
11/14/17

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: 3 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Monique Katsuki, MD

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

Date 11/14/17

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

MEDICAL BOARD
NOV 24 2017

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