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) 9 (Day) 17 (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: 12/29/17

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: Med ab procedure was initiated on 12/9/17 per FDA regimen. Pt returned for f/u ultrasound on 12/29/17 and uterine debris was noted. Surgical aspiration was performed at that time, pt did well post op.

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

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

Date 1/5/18

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

MEDICAL BOARD
JAN 17 2018

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) 16 (Day) 17 (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: 12/22/17

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: Med ab procedure was initiated on 12/16/17 per FDA regimen. Flu ultrasound on 12/22/17 showed remaining uterine debris. Pt chose to have 2nd dose of misoprostol but returned on 12/28/17 due to continued pain + heavy bleeding. Surgical aspiration was performed; pt did well post-op.

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

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

Date 1/20/18

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

MEDICAL BOARD
JAN 26 2018

Prescribed: 5/4/2011, Rev. 12/13/12

2

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) 20 (Day) 17 (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: 1/4/18

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: 1 Hours _____ Days

7. Remarks: Med ab. procedure initiated per FDA regimen on 12/20/17. Following b/duc on 1/4/18 indicated an incomplete abortion. Pt was given repeat dose of misoprostol on 1/4/18. Results of b/duc on 1/9/18 indicated incomplete process. Pt refuses to return for further treatment.

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

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

Date 2/7/18

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

MEDICAL BOARD

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: 1 (Month) 13 (Day) 2017 (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: 2/3/17

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) Hematometra

6. Duration of event: 1 Hours 5 Days

7. Remarks: Pt. had medication abortion on 1/13/17. F/u bloodwork confirmed complete abortion. Subsequently, patient complained of increased bleeding and aspiration performed on 2/8/17. Pt. is well post-op.

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

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

Date 3/3/17

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

MEDICAL BOARD
MAR 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: 2 (Month) 28 (Day) 17 (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: 3/17/17

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) hematometra

6. Duration of event: 1 Hours _____ Days

7. Remarks: Medication abortion started on 2/28/17. Pt reported increased bleeding and cramping two weeks later. Suction procedure was done on 3/17/17 for hematometra. Pt did well post op.

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

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

Date 4/14/17

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

MEDICAL BOARD
APR 20 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: 2 (Month) 28 (Day) 2017 (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: 4/19/17

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: Med ab per FDA regimen on 2/28/17. Pt returned for post-abortion follow up on 4/19/17. Bldwork showed <80% drop in HCG. Ultrasound on 4/25/17 showed continued pregnancy. D+E was performed on 4/26/17. Pt did well post-op.

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

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

Date 5/9/17

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

MEDICAL BOARD
MAY 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: 3 (Month) / 3 (Day) / 2017 (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: 4/12/17

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: 1 Hours _____ Days

7. Remarks: Med. ab. per FDA regimen on 3/3/17. Pt did not return for scheduled follow up in 2wks - returned on 4/12/17 for post-ab ultrasound. Results showed continued pregnancy. D+E performed on 4/13/17. Pt did well post-op.

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: 5/9/17

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

MEDICAL BOARD
MAY 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: March (Month) 11 (Day) 2017 (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: 3/16/17

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: persistent gestational sac noted on ultrasound at MAB follow-up visit on 3/16/17. Suction procedure done and pt. did well post-op.

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

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

Date 4/14/17

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

MEDICAL BOARD
APR 20 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: 3 (Month) 22 (Day) 17 (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:
5/19/17

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: Med abortion process started on 3/22/17. Pt did not have follow up bloodwork as instructed. Ultrasound on 5/19/17 showed continued pregnancy. Surgical abortion was done on 5/19/17 and pt. did well post-op.

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

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

Date 6/16/17

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

MEDICAL BOARD
JUN 28 2017

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

16K

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: 3 (Month) / 31 (Day) / 2017 (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: 4/6/17

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) hematometra

6. Duration of event: 1 Hours ___ Days

7. Remarks: Medication abortion per FDA regimen on 3/31/17. Pt. reported heavy bleeding and cramping intermittently on 4/5/17. Aspiration was performed on 4/6/17. pt did well post op.

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 5/9/17

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

MEDICAL BOARD
MAY 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: 4 (Month) 14 (Day) 17 (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:
5/2/17

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: Med abortion process started on 4/14/17. Follow up bloodwork showed incomplete abortion. Aspiration done at PPGOH on 5/3/17 and pt. did well post-op.

8. a. Name of physician who provided RU-486 TIMOTHY S. KRESS, MD

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

Date 6/15/17

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

MEDICAL BOARD
JUN 22 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: 4 (Month) 27 (Day) 17 (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:
5/12/17

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: 1 Hours ___ Days

7. Remarks: Med abortion procedure started on 4/27/17. Follow up ultrasound showed continued pregnancy. Surgical abortion done on 5/12/17 and pt. did well post-op

8. a. Name of physician who provided RU-486 TIMOTHY S. KRESS, MD

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

Date 6/15/17

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: 5 (Month) 5 (Day) 17 (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: 5/18/17

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: Med abortion procedure started on 5/5/17. Follow up ultrasound showed continued pregnancy. surgical abortion done 5/19/17 and pt. did well post-op

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

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

Date 6/16/17

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

MEDICAL BOARD
JUN 22 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: 5 (Month) / 9 (Day) / 17 (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: 6/27/17

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: Med abortion was initiated per FDA regimen on 5/9/17. Pt. returned for follow-up ultrasound on 6/27/17 - continuing pregnancy was confirmed. Surgical abortion was performed on 6/28/17; pt did well post-op.

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

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

Date 7/19/17

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

MEDICAL BOARD
JUL 3 7 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: 5 (Month) / 11 (Day) / 17 (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: 5/25/17

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: 1 Hours ___ Days

7. Remarks: Med. ab. was initiated per FDA regimen on 5/11/17. Follow-up exam indicated an incomplete abortion - persistent gestational sac. Surgical aspiration was done on 6/16/17; Pt did well post-op.

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

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

Date 7/19/17

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

JUL 27 2017

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

BK

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: 5 (Month) 12 (Day) 17 (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: 5/26/17

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: Med. abortion process begun 5/12/17. Followup ultrasound showed continued pregnancy. Surgical abortion done 5/31/17 and pt. did well post op.

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

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

Date 6/15/17

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

MEDICAL BOARD
JUN 22 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: 5 (Month) / 16 (Day) / 17 (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:
5/25/17

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: 1 Hours _____ Days

7. Remarks: Med. abortion process began 5/16/17. Followup bloodwork showed incomplete abortion. Aspiration done at PPFOH on 5/25/17 and pt did well post op.

8. a. Name of physician who provided RU-486 TIMOTHY S. KRESS, MD

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

Date 6/15/17

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

MEDICAL BOARD
JUN 22 2017

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

18K

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: 5 (Month) 16 (Day) 17 (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: 6/2/17

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:
Med. abortion was initiated per FDA regimen on 5/16/17. Follow-up bloodwork indicated a failed abortion. Surgical aspiration was done on 6/7/17; pt. did well post op.

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

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

Date 7/19/17

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

MEDICAL BOARD
JUL 27 2017

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

192

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: 5 (Month) / 24 (Day) / 17 (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: 6/7/17

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: Med. abortion was initiated per FDA regimen on 5/24/17. Follow-up ultrasound showed a continuing pregnancy. Surgical abortion was done on 6/7/17; pt did 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 7/19/17

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

JUL 27 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: 6 (Month) / 10 (Day) / 17 (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: 6/22/17

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: 1 Hours _____ Days

7. Remarks: Med abortion initiated per FDA regimen on 6/10/17. Follow-up bloodwork and ultrasound indicated a failed abortion. Surgical aspiration was done on 6/22/17; pt. did well post-op.

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

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

Date 7/19/17

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

21-12

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: 6 (Month) 16 (Day) 17 (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: 6/27/17

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: Med abortion initiated per FDA regimen on 6/16/17. Follow-up ultrasound showed a continuing pregnancy. Surgical aspiration was done on 6/27/17, pt did well post op

8. a. Name of physician who provided RU-486 TIMOTHY KRESS, M.D.

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

Date 7/19/17

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

MEDICAL BOARD
JUL 27 2017

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

18K

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: 7 (Month) 12 (Day) 17 (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: 7/19/17

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: Med abortion process was initiated per FDA regimen on 7/12/17. Followup ultrasound on 7/19/17 showed an ongoing pregnancy. Surgical aspiration was done on 7/20/17, pt did 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 8/15/17

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

29c

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: 7 (Month) 13 (Day) 17 (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: 7/17/17

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: Med abortion process initiated per FDA regimen on 7/13/17 second dose of misoprostol was given on 7/17/17 due to lack of results from first dose. Follow-up ultrasound on 7/19/17 showed ongoing pregnancy. Surgical aspiration was performed and pt did well post-op.

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

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

Date 8/15/17

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

AUG 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: 7 (Month) 19 (Day) 17 (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: 8/2/17

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: Medication abortion procedure was initiated per FDA regimen on 7/19/17. At follow-up visit, ultrasound revealed continued pregnancy. Surgical abortion was performed the same day and pt. did 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 9/1/17

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

MEDICAL BOARD
SEP 15 2017

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

25K

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) 1 (Day) 17 (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: 8/18/17

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: Med abortion procedure was initiated per FDA regimen on 8/1/17. Bloodwork on 8/18/17 and ultrasound on 8/22/17 revealed an incomplete abortion. Pt chose to repeat the medication regimen on 8/22/17; ultrasound on 8/29/17 showed abortion was complete.

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

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

Date 9/1/17

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

MEDICAL BOARD
SEP 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: 8 / 1 / 17 (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: 8/15/17

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: Medication abortion procedure was initiated per FDA regimen on 8/1/17. At follow-up visit on 8/15/17, ultrasound revealed a continuing pregnancy. Surgical abortion was done the same day and pt. did well post-op.

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

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

Date 9/1/17

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

MEDICAL BOARD
SEP 15 2017

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

23K

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) / 2 (Day) / 17 (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: 10/3/17

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: Med ab procedure started 8/2/17 per FDA protocol. Pt. returned for follow up on 10/3/17 at which time ultrasound showed a continuing pregnancy. Surgical abortion was performed on 10/14/17; pt did 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 11/10/2017

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

MEDICAL BOARD
NOV 17 2017

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

28K

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) / 9 (Day) / 17 (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: 8/15/17

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: Medication abortion procedure was initiated per FDA regimen on 8/9/17. At follow-up visit on 8/15/17, ultrasound revealed a continuing pregnancy. Surgical abortion was done on 8/17/17 and she did well post op.

8. a. Name of physician who provided RU-486 _____

8. b. Physician's signature _____ MD / DO Andrey Fetisov, MD

Date _____ 9/5/2017

MEDICAL BOARD OCT 04 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

29P

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 / 15 / 17 (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: 8/24/17

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: Medication abortion procedure was initiated per FDA regimen on 8/15/17. At follow-up visit on 8/24/17, ultrasound showed absence of gestational sac, but incomplete abortion. Surgical aspiration was done on 8/24/17 and pt. did 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 9/1/17

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

MEDICAL BOARD
SEP 15 2017

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

36K

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) / 8 (Day) / 17 (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: 10/14/17

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: Pred. at procedure started 9/8/17 per FDA protocol. Pt. returned for follow-up on 10/14/17 at which time ultrasound showed a continuing pregnancy. Surgical abortion was performed on 10/14/17; pt did well post-op.

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

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

Date 11/10/2017

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

MEDICAL BOARD
NOV 17 2017

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

37K

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 / 8 / 17 (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: 9/19/17

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: Medication ab procedure started on 9/8/17. Follow-up bloodwork + ultrasound showed continuing pregnancy. Surgical aspiration completed on 9/23/17; 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 10/6/17

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

OCT 20 2017

MEDICAL BOARD
OCT 20 2017

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

32

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) 13 (Day) 17 (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: 3350 Rockside Rd. Bedford Heights, OH 44146

4. Date post RU-486 complication began: 10/3/17

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: Med abortion procedure started 9/13/17 per FDA protocol. Follow-up bloodwork on 10/3/17 indicated an incomplete abortion and ultrasound showed a continuing pregnancy. Surgical abortion was performed on 10/31/17, pt did well post op

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

8. b. Physician's signature Timothy Krees (MD)/DO

Date 11/10/2017

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

MEDICAL BOARD
NOV 17 2017

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

39K

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 / 27 / 17 (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:
10/11/17

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: Med abortion procedure started on 9/27/17 per FDA protocol. Follow up consultation on 10/11/17 showed incomplete abortion. Surgical abortion was done on 10/10/17, pt. doing well post op.

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

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

Date 11/10/2017

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

MEDICAL BOARD
NOV 17 2017

Prescribed: 5/–/2011, Rev. 12/13/12

39K

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) / 16 (Day) / 17 (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: 12/9/17

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: _____ Hours _____ Days

7. Remarks: Med ab procedure instiated per FDA regimen on 10/16/17. Pt. did not keep F/U appt, but went to ER on 12/9 for bleeding + cramping; was referred to PPGOH for treatment. Pt. had F/U ultrasound at PPGOH on 12/27 which showed "uterine debris." Pt had surgical aspiration on 1/10/18 and did 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 2/7/18

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

MEDICAL BOARD

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

35

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) 21 (Day) 17 (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: 11/10/17

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: Med ab process was initiated on 10/21/17, following FDA criteria. Follow-up ultrasound on 11/10 showed continuing pregnancy. Surgical ab was done on 11/16/17 and pt. did well post-op.

8. a. Name of physician who provided RU-486 Andrey Bernikov MD/DO

8. b. Physician's signature ___

Date 12/5/17

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

STATE MEDICAL BOARD
DEC 8 2017

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

38-P

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 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: 1/25/18

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: 1 Hours _____ Days

7. Remarks: Med ab. procedure initiated per FDA regimen on 11/20/17. Follow up ultrasound on 1/25/18 showed uterine debris. surgical aspiration was done on 1/26/18; pt. did 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 2/7/18

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

MEDICAL BOARD

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

38L

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: 1 (Month) / 8 (Day) / 18 (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:
1/25/18

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: 1 Hours _____ Days

7. Remarks: Med. ab procedure was initiated per FDA regimen on 1/8/18. Follow up ultrasound on 1/25/18 showed a continuing pregnancy. Surgical procedure was done on 1/30/18; pt. did 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 2/7/18

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

MEDICAL BOARD

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

4

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: 1 / 8 / 18 (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: 1/25/18

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: 1 Hours ___ Days

7. Remarks: Med ab procedure initiated per FDA regimen on 1/8/18. Follow up ultrasound on 1/25/18 showed "uterine debris". Surgical aspiration was done on 1/29/18; pt did 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: 2/7/18

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