State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

Date RU-486 was provided:	January Month	\2_ Day	Zo12 Year	
2. Name of medical practice or facility at v	vhich RU-486 was pr	ovided:	Mark Mark Mark Mark Mark Mark Mark Mark	
Central Ohio Women's	Center			
3. Address of medical practice or facility at	which RU-486 was j	provided:		
3255 East Main St	Columbus	. oH u	13213	
4. Date post RU-486 event began:	10/12			
5. Event(s) (Please check all that apply):			***************************************	
Incomplete abortion Adve	rse reaction to RU-486	Patient	t hospitalized	
Patient received a transfusion Severe bleeding				
X Other serious event (specify) Moduate bludue				
6. Duration of event: Hours Days				
7. Remarks: Dand C done for mo novine followy.	duchly heary be	leef , at her	u ob	
8. a. Name of physician who provided RU-	486 <u>Keder</u>	•		
8. b. Physician's signature	Mate 5/1/12.		M.D. / D.O	
Send completed forms to: State Me	dical Board of Ohio	A second		

Legal Department

2012 HA IS YAH SIOL

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDIGAL BOARD

MAY 21 2012

STATE MEDICAL BOARD OIHO TO

Prescribed: 5/--/2011

Rept#7

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided	: March		19	2012
2. Name of medical practice of		was provid	Day	Year
	•	was provide	eu.	
Central Onio wa	men's Center	<u></u>		Action and the state of the sta
3. Address of medical practice	or facility at which RU-48	6 was provi	d ed :	**************************************
3755 East Ma	· < + C. lb.	, A H		
4. Date post RU-486 event be		3, O H		
4. Date post 110 400 bronk be	gan.			
5. Event(s) (Please check all t	hat apply):			
Incomplete abortion	Adverse reaction to F	11 1-486	Patient	hospitalized
Plus approximation		10 TOO	· Zueri	. Hoopitalizot
Patient received a transfusion	Severe bleeding			
Other serious event (specify)				
	<u> </u>			- Andrews - Andr
6. Duration of event:	Hours Day	5		
7. Remarks:				
	•			
3. a. Name of physician who p	rovided RU-486 C	Haerin	e Co	nswo
8. b. Physician's signature	Win	X		M.D. / D.O
o. o. i riyololdii o digilatalo	Date	5/14	112	(11.0.)
Send completed forms to:	State Medical Board of	f Obje		
sena compietea ionna to.	Legal Department	i Onio		
	30 E. Broad St., 3 rd Fl	oor	11	AEUIUAL DUA
	Columbus, OH 43215			MAY 2 4 2012

Rept # 12

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	4	4	LOR
	Month	Daý	Year
	r facility at which RU-486 was p	rovided:	
(rentral Oh	id Women's (t	ater	
3. Address of medical practice	or facility at which RU-486 was	provided:	
3155 E. Ma	in Street Colum	n bus Ohio	43213
4. Date post RU-486 event beg	gan: 4-12-12		
5. Event(s) (Please check all the	nat apply):		
	Adverse reaction to RU-486	Patient hos	spitalized
Patient received a transfusion	Severe bleeding		
Other serious event (specify)			
6. Duration of event:	Hours 14 Days		
7. Remarks:			
8. a. Name of physician who p	rovided RU-486 _,		
8. b. Physician's signature	Must.	mfu us	M.D. / D.O
0, 2. 1 / , , 	Date	5785/12	
Send completed forms to:	State Medical Board of Ohio		
	Legal Department		
	30 E. Broad St., 3 rd Floor	Communication of the state of t	EDIGAL BOAF
	Columbus, OH 43215-6127		- Aur BAYE

MAY 3 1 2012

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

				1	
1. Date RU-486 was provided	d:	05	10	20/2	
		Month	Day	Year	
2. Name of medical practice or facility at which RU-486 was provided:					
1 PENTRAK	0/410	WMap's	(Carrell,		
3. Address of medical practice					
3/55 E. MA	112 5/1286	T Cohui	ribus, ONO	43213	
4. Date post RU-486 event be	gan: 194-04-1		,		
5. Event(s) (Please check all t				# 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	
Incomplete abortion	Adverse	reaction to RU-486	Patient hos	pitalized	
Patient received a transfusion	Severe	bleeding			
Other serious event (specify) _					
6. Duration of event:	Hours	Days			
7. Remarks:		25-11			
7. Hemano.					
		0	-		
8. a. Name of physician who p	provided RU-48	36 CUHU	nue Cas	USINO IND	
	7	1111	>	M.D. / D.O	
8. b. Physician's signature			111/12	IVI.D. / D.O	
	Dat	e	111/10		
Send completed forms to:	State Medic	cal Board of Ohio	8 A.W.		
	Legal Depa			GAL BUARD	
	30 E. Broad	d St., 3 rd Floor			
	Columbus.	OH 43215-6127	<i>4</i> 9	M 18 2012	