Rept #1

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physicisn who provided RU-486

1. Date RU-486 was provided: 04 (Month) 13 (Day) 2011 (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 event began: 04/27/2011

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 2 Days

7. Remarks:
Abortion completed surgically 4/29/11, no further complication.

8. a. Name of physician who provided RU-486 Rebecca Lowenthal, M.D.

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

Date 7/13/11

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

Prescribed: 5/--/2011

MEDICAL BOARD
JUL 19 2011

Rpt #2

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: 05 (Month) 04 (Day) 2011 (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 event began: 05/11/11

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: 2 Hours _____ Days

7. Remarks:
Abortion completed surgically 5/11/11, no further complication.

8. a. Name of physician who provided RU-486 Lisa Perriera, M.D.

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

Date 7/12/11

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

Prescribed: 5/--/2011

✓ Rept #3

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: July (Month) 12 (Day) 2011 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
19550 Rockside Rd Bedford, OH 44146

4. Date post RU-486 event began:
8/15/11

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: 35 Hours _____ Days
per pt report

7. Remarks:

8. a. Name of physician who provided ~~RU-486~~ David Burkons, MD

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

Date 9/2/11

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

Prescribed: 5/--/2011

✓ Rept # 4

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: 12 (Month) 9 (Day) 11 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
19550 Rockside Rd Bedford OH 44146

4. Date post RU-486 event began:
12/22/11

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 Sarah K Smith, MD

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

Date 1/24/12

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

Prescribed: 5/--/2011

✓ Rept #5

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: 12 (Month) 27 (Day) 11 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
19560 Rockside Rd Bedford OH 44146

4. Date post RU-486 event began:
1/14/12

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 for persistent sac

8. a. Name of physician who provided RU-486 David Burkons MD

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

Date 1/26/12

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

Prescribed: 5/–/2011

Rept #6

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: January (Month) 12 (Day) 2012 (Year)

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

Central Ohio Women's Center

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

3255 East Main St Columbus, OH 43213

4. Date post RU-486 event began: 2/10/12

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) moderate bleeding

6. Duration of event: 2 Hours _____ Days

7. Remarks: D and C done for moderately heavy bleeding at time of routine follow up.

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

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

Date 5/7/12.

Send completed forms to:

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

MEDICAL BOARD
MAY 21 2012

STATE MEDICAL BOARD OF OHIO
2012 MAY 21 AM 8:04

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 (Month) 19 (Day) 2012 (Year)

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

Central Ohio Women's Center

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

3255 East Main St Columbus, OH

4. Date post RU-486 event 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: _____ Hours _____ Days

7. Remarks:

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

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

Date 5/14/12

Send completed forms to:

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

MEDICAL BOARD
MAY 24 2012

Prescribed: 5/--/2011

Rept #8

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: 01 (Month) 19 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
19550 ROCKSIDE RD. BEDI

4. Date post RU-486 event began:
2/17/12

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

✓ Incomplete abortion
___ Adverse reaction to RU-486
___ Patient hospitalized
___ Patient received a transfusion
___ Severe bleeding
___ Other serious event (specify) _____

6. Duration of event: 1 Hours 8 Days

7. Remarks:
Pt never returned for F/U so dont know if completed on her own

8. a. Name of physician who provided RU-486 DR. DAVID BURKONS

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

Date 5/16/12

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

2012 MAY 29 PM 2:15
STATE MEDICAL BOARD OF OHIO

MEDICAL BOARD
MAY 29 2012

Prescribed: 5/--/2011

Rept #9

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: 12 (Month) 01 (Day) 2011 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
19550 ROCKSIDE RD, BEDFORD, OH 44146

4. Date post RU-486 event began:
12/15/11

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) HEMATOMETRA~~ error

6. Duration of event: 0 Hours 13 Days

7. Remarks:

8. a. Name of physician who provided RU-486 DR. DAVID BURKONS

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

Date 5/4/12

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

2012 MAY 29 PM 2:15
STATE MEDICAL BOARD OF OHIO

MEDICAL BOARD
MAY 29 2012

Prescribed: 5/--/2011

Rept # 10

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:	11	01	2011
	Month	Day	Year

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

PPNEO

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

19550 ROCKSIDE RD, BEDFORD, OH 44146

4. Date post RU-486 event began:

11/17/11

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

✓ Incomplete abortion

___ Adverse reaction to RU-486

___ Patient hospitalized

___ Patient received a transfusion

___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours ___ Days

7. Remarks:

8. a. Name of physician who provided RU-486 DR. SARAH SMITH

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

Date 5/22/12

Send completed forms to:

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

Prescribed: 5/--/2011

Rept #11

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: 10 (Month) 4 (Day) 2011 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
19550 ROCKSIDE RD, BEDFORD, OH 44146

4. Date post RU-486 event began:
10/18/11

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) HEMATOMETRA

6. Duration of event: 1 Hours 0 Days

7. Remarks:

8. a. Name of physician who provided RU-486 DR. SARAH SMITH

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

Date 5/22/12

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

Prescribed: 5/--/2011

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 (Month) 4 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3155 E. Main Street Columbus, Ohio 43213

4. Date post RU-486 event began: 4-12-12

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 14 Days

7. Remarks:

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

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

Date 5/30/12

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

rept # 13

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: 05 (Month) 17 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 ROCKSIDE RD
BEDFORD HEIGHTS, OH 44146

4. Date post RU-486 event began:
6-6-12

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

✓ Incomplete abortion
___ Adverse reaction to RU-486
___ Patient hospitalized
___ Patient received a transfusion
___ Severe bleeding
___ Other serious event (specify) _____

6. Duration of event: 1 Hours 0 Days

7. Remarks:

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JUN 13 2012

8. a. Name of physician who provided RU-486 DAVID BURKONS, MD

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

Date 6/6/12

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

Prescribed: 5/--/2011

Rept #14

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: 5 (Month) 29 (Day) 12 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 ROCKSIDE RD
BEDFORD HTS, OH 44146

4. Date post RU-486 event began:
6-7-12

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

✓ Incomplete abortion
___ Adverse reaction to RU-486
___ Patient hospitalized
___ Patient received a transfusion
___ Severe bleeding
___ Other serious event (specify) _____

6. Duration of event: 1 Hours Ø Days

7. Remarks:

8. a. Name of physician who provided RU-486 DR. DAVID BURKONS

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

Date 6/8/12

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

Prescribed: 5/--/2011

Rpt# 15

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: 05 (Month) / 16 (Day) / 2012 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
CENTRAL OHIO WOMEN'S CENTER

3. Address of medical practice or facility at which RU-486 was provided:
3455 E. MAIN STREET COLUMBUS, OHIO 43213

4. Date post RU-486 event began:
04-04-12

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:

8. a. Name of physician who provided RU-486 Catherine Carsino, MD

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

Date 6/11/12

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

MEDICAL BOARD
JUN 18 2012

Prescribed: 5/--/2011

Rpt #10

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: 11 (Month) 10 (Day) 2011 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
19550 ROCKSIDE RD, BEDFORD, OH 44146

4. Date post RU-486 event began: 12/3/11

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) HEMATOMETRA

6. Duration of event: 1 Hours Ø Days

7. Remarks:

8. a. Name of physician who provided RU-486 DR. SARAH SMITH

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

Date 6/12/12

Send completed forms to:

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

Prescribed: 5/--/2011

Rpt 17

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: 5 (Month) 8 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd Bedford Hts OH 44146

4. Date post RU-486 event began:
6/15/12

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

✓ Incomplete abortion
___ Adverse reaction to RU-486
___ Patient hospitalized
___ Patient received a transfusion
___ Severe bleeding
___ Other serious event (specify) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 David Burkons MD

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

Date _____

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

MEDICAL BOARD
JUN 28 2012

Prescribed: 5/--/2011

Rpt 18

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: 06 (Month) 07 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 ROCKSIDE RD
BEDFORD HEIGHTS, OH 44146

4. Date post RU-486 event began:
6-21-12

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: Ø Hours 1 Days

7. Remarks:

8. a. Name of physician who provided RU-486 DR DAVID BURKONS

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

Date 6/27/12

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

Rept 19

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: 08 (Month) 15 (Day) 12 (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. Cleve. OH 44120

4. Date post RU-486 event began:
09/08/12

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:
Abortion completed surgically 9/8/12, no further complication.

8. a. Name of physician who provided RU-486 Rebecca Lowenthal, M.D.

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

Date 9/21/12

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

Rept 20

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: 08 (Month) 30 (Day) 2012 (Year)

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

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

4. Date post RU-486 event began: 9/12/12

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:
Abortion completed surgically 9/12/12, no further complication.

8. a. Name of physician who provided RU-486 Lisa Derrico, M.D.

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

Date 9/14/12

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

Report #21

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: Oct (Month) 4 (Day) 2011 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
19550 Rockside Rd Bedford OH 44146

4. Date post RU-486 event began:
10/21/11

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: in-clinic suction performed without complication for failed medication abortion

8. a. Name of physician who provided RU-486 [signature] MD

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

Date 11/8/11

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

Prescribed: 5/--/2011

Report #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: 3 (Month) 6 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd Bedford Hts OH 44146

4. Date post RU-486 event began:
3/20/12

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

✓ Incomplete abortion
___ Adverse reaction to RU-486
___ Patient hospitalized
___ Patient received a transfusion
___ Severe bleeding
___ Other serious event (specify) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Sarah K Smith MD

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

Date 3/27/12

Send completed forms to:

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

MEDICAL BOARD
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Prescribed: 5/--/2011

2011-1981

Report #23

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: 3 (Month) 7 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd Bedford Hts OH 44146

4. Date post RU-486 event began:
3/20/12

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

✓ Incomplete abortion
___ Adverse reaction to RU-486
___ Patient hospitalized
___ Patient received a transfusion
___ Severe bleeding
___ Other serious event (specify) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 David Burnons MD

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

Date 3/28/11

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

Report #24

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: 3 (Month) 27 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd
Bedford Hts OH 44146

4. Date post RU-486 event began: 4/14/12

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

✓ Incomplete abortion
___ Adverse reaction to RU-486
___ Patient hospitalized
___ Patient received a transfusion
___ Severe bleeding
___ Other serious event (specify) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Sarah K Smith MD

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

Date 4/24/12

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

Prescribed: 5/--/2011

Report #25

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: 3 (Month) 28 (Day) 12 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd Bedford Hts OH 44146

4. Date post RU-486 event began:
4/13/12

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

✓ Incomplete abortion
___ Adverse reaction to RU-486
___ Patient hospitalized
___ Patient received a transfusion
___ Severe bleeding
___ Other serious event (specify) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 David M Burkons MD

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

Date 4/19/12

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

MEDICAL BOARD
MAY 04 2012

Prescribed: 5/--/2011

Report #26

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: 3 (Month) 13 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd
Bedford Hts OH 44146

4. Date post RU-486 event began:
4/5/12

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

✓ Incomplete abortion
___ Adverse reaction to RU-486
___ Patient hospitalized
___ Patient received a transfusion
___ Severe bleeding
___ Other serious event (specify) _____

6. Duration of event: ___1___ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Sarah K Smith MD

8. b. Physician's signature _____ M.D. / D.O
Date 5/1/12

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

Report #27

State Medical Board of Ohio

Report of RU-486 Event

MEDICAL BOARD

SEP 10 2012

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: June (Month) 12 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25360 Rockside Rd
Bedford Hts, OH

4. Date post RU-486 event began:
6/29/12

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

✓ Incomplete abortion
___ Adverse reaction to RU-486
___ Patient hospitalized
___ Patient received a transfusion
___ Severe bleeding
___ Other serious event (specify) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Sarah K Smith MD

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

Date 9/4/12

Send completed forms to:

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

Prescribed: 5/--/2011

Report # 28

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: 9 (Month) 12 (Day) 12 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
CENTRAL OHIO WOMEN'S CENTER

3. Address of medical practice or facility at which RU-486 was provided:
3155 E. MAIN STREET Col's, Oh. 43213

4. Date post RU-486 event began:
10/12/12

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: 24 Hours Ø Days

7. Remarks: Pt underwent D&C for incomplete medical abortion.

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

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

Date 10/12/12

Send completed forms to:

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

Prescribed: 5/--/2011

Report #29

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: July (Month) 3 (Day) 2012 (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 Hts, OH 44146

4. Date post RU-486 event began:
7/19/2012

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 ___1___ Days

7. Remarks:

8. a. Name of physician who provided RU-486 David Burkons, MD

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

Date 1/8/13

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

Report #30

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: August (Month) 30 (Day) 2012 (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 Hts, OH 44146

4. Date post RU-486 event began:
9/15/2012

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 1 ~~3~~ error Days

7. Remarks:

8. a. Name of physician who provided RU-486 David Burkons, MD

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

Date 1/18/13

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

Report #31

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:	Sept (Month)	18 (Day)	2012 (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 Hts, OH 44146

4. Date post RU-486 event began:
10/2/12

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 1 Days

7. Remarks:

8. a. Name of physician who provided RU-486 Sarah Smith, MD

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

Date 1/15/13

Send completed forms to:

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

Report #32

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:	10 (Month)	31 (Day)	2012 (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 HTS, OH 44146

4. Date post RU-486 event began:
11/16/12

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) INFECTION

6. Duration of event: 0 Hours 14 Days

7. Remarks: TREATED WITH PO ANTIBIOTICS x 14 DAYS

8. a. Name of physician who provided RU-486 Dr DAVID BURKONS, M.D.

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

Date 1/16/13

Send completed forms to:

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

Report # 33

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:	10	17	2012
	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 HTS, OH 44146

4. Date post RU-486 event began:

11-8-12

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

___ Incomplete abortion

___ Adverse reaction to RU-486

___ Patient hospitalized

___ Patient received a transfusion

✓ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours ___ Days

7. Remarks:

8. a. Name of physician who provided RU-486 DR DAVID BURKONS, MD

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

Date 1/16/13

Send completed forms to:

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

Report #34

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: 11 (Month) 8 (Day) 2012 (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 HTS, OH 44146

4. Date post RU-486 event began:
11/27/12

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: Ø Hours 3 Days

7. Remarks:

8. a. Name of physician who provided RU-486 DR DAVID BURKONS, MD

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

Date 1/16/13

Send completed forms to:

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

Prescribed: 5/--/2011

Report # 35

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: 11 (Month) 14 (Day) 2012 (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 HTS, OH 44146

4. Date post RU-486 event began:
11/30/12

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) HEMATOMETRA TREATED WITH ASPIRATION

6. Duration of event: <1 Hours 8 Days

7. Remarks:

8. a. Name of physician who provided RU-486 DR DAVID BURKONS, MD

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

Date 1/18/13

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

Report #36

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: 10 (Month) 17 (Day) 2012 (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 HTS, OH 44146

4. Date post RU-486 event began:
10/27/12

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: 0 Hours 3 Days

7. Remarks:

8. a. Name of physician who provided RU-486 DR DAVID BURGONS, M.D.

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

Date 1/18/13

Send completed forms to:

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

Report #37

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) 11 (Day) 2012 (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 OH 44120

4. Date post RU-486 complication began: 1/2/13

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: ~~X~~ zero Hours 7 Days

7. Remarks:
Abortion completed surgically on 1/9/13, no further complications.

8. a. Name of physician who provided RU-486 Mohammed Rezaee

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

Date 1/22/13

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

MEDICAL BOARD
JAN 28 2013

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

Report #38

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: 7 (Month) 17 (Day) 12 (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 HTS, OH 44146

4. Date post RU-486 event 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: 21 Hours 0 Days

7. Remarks:

MEDICAL BOARD
APR 15 2013

8. a. Name of physician who provided RU-486 DR SARAH LONGEN

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

Date 4/9/13

Send completed forms to:

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

Prescribed: 5/--/2011

report # 39

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: 2 (Month) 19 (Day) 13 (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 HTS, OH 44146

4. Date post RU-486 event began: 3/8/13

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: 0 Hours 1 Days

7. Remarks:

MEDICAL BOARD APR 15 2013

8. a. Name of physician who provided RU-486 DR SARAH LENGEN

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

Date 4/9/13

Send completed forms to:

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

Prescribed: 5/--/2011

report #40

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: 2 (Month) 5 (Day) 2013 (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 HTS, OH 44146

4. Date post RU-486 event began: 2-22-13

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

- ✓ Incomplete abortion
- ___ Adverse reaction to RU-486
- ___ Patient hospitalized
- ___ Patient received a transfusion
- ___ Severe bleeding
- ___ Other serious event (specify) _____

6. Duration of event: <1 Hours 0 Days

7. Remarks:

8. a. Name of physician who provided RU-486 DR SARAH LENGEN

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

Date 4/9/13

Send completed forms to:

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

MEDICAL BOARD
APR 15 2013

Prescribed: 5/--/2011

report #4

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: 2 (Month) 26 (Day) 2013 (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 HTS, OH 44146

4. Date post RU-486 event began:
3-14-13

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

- ✓ Incomplete abortion
- ___ Adverse reaction to RU-486
- ___ Patient hospitalized
- ___ Patient received a transfusion
- ___ Severe bleeding
- ___ Other serious event (specify) _____

6. Duration of event: <1 Hours 6 Days

7. Remarks:

MEDICAL BOARD
APR 15 2013

8. a. Name of physician who provided RU-486 DR SARAH LENGEN

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

Date 4/9/13

Send completed forms to:

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

Prescribed: 5/--/2011

report #42

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: 03 (Month) 27 (Day) 2013 (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 OH 44120

4. Date post RU-486 complication began:
4/19/13

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 ___1___ Days

7. Remarks:
Abortion completed surgically on 4/20/13, no further complication.

8. a. Name of physician who provided RU-486 Mohammad Rezaee

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

Date 4.24.13

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

MEDICAL BOARD
APR 29 2013

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