

(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provided:	. 10	17 2012
	Month	Day Year
2. Name of medical practice or fa	cility at which RU-486 was provide	d:
PLANNED PARENTHOOP	OF GREATER OHO	
3. Address of medical practice or to 25350 Rocks DE R		ded:
BEDFORD HTS, OH 4		
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:8I	lours <u></u> 2 Days	
7. Remarks:		
		/ /
8. a. Name of physician who provide	ded RU-486 AR JANTO	BURICONS, M.D.
8. b. Physician's signature		M.D. / D.O
	Date	1/18/13
Send completed forms to:	tate Medical Board of Ohio	
L	egal Department	MEDICAL BOARD
	0 E. Broad St., 3 rd Floor	JAN 2 4 2013
C	olumbus, OH 43215-6127	
	· ·	
Prescribed: 5//2011		



(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provided:	JI	14 2012
	Month	Day Year
2. Name of medical practice or fa	cility at which RU-486 was provide	ed:
·	OF GREATER OTHO	
3. Address of medical practice or f	acility at which PLL-186 was provi	dod:
25350 ROCKSIDE NO	acility at Which HO-400 was provid	iea.
BEDFORD HTS, OH 41	1146	
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)	m Atom etra thenten u	SITH REASPIRATION
6. Duration of event:	Hours <u>&</u> Days	
7. Remarks:		
8. a. Name of physician who provide	ded BUASE PR DAVID	BURKONS, MD
8. b. Physician's signature		(M.D) D.O
o. b. r nysician s signature	Date ///8///	(W.D.) U.O
Send completed forms to:	State Medical Board of Ohio	
	egal Department	
	0 E. Broad St., 3 rd Floor	MEDICAL BOARD
	olumbus, OH 43215-6127	unding DEMILL
_		JAN 8 4 2013
Prescribed: 5//2011	,	

Report #34



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provided:		8 2012
	Month	Day Year
2. Name of medical practice or fa	cility at which RU-486 was provide	d:
PLANNED PARENT		
3. Address of medical practice or t	acility at which RU-486 was provid	ded:
25350 RAGUSIDE	RO, BEDFURD ITT	3, 0H 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:	Hours 3 Days	
7. Remarks:		
8. a. Name of physician who provide	ded FIV.486 DR DAVIN	BLAKONS, MD
8. b. Physician's signature	Date Date	M.D./D.O
Send completed forms to:	tate Medical Board of Ohio	
	egal Department	MEDICAL BOARD
3	0 E. Broad St., 3 rd Floor	JAN 2 4 2013
C	olumbus, OH 43215-6127	wante m w frequency
Prescribed: 5//2011	·	



(Required pursuant to R.C. 2119.123)

	e de la companya de l	
1. Date RU-486 was provided:	10	17 2012
	Month	Day Year
2. Name of medical practice or fa	cility at which RU-486 was provide	d:
PLANNED PAREN	THOOD OF GREATEN	0170
25350 ROULSIDE	†	ded:
BEDFORD HTS, OH	44146	
4. Date post RU-486 event began リーマース		
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 provi	ded RU-486 DA DAVID A	unicods, MD
8. b. Physician's signature	Date //6/	M.D. / D.O
Send completed forms to:	State Medical Board of Ohio	
l	egal Department	
	30 E. Broad St., 3 rd Floor	MEDICAL BOARD
	Columbus, OH 43215-6127	JAN 2 4 2013
Prescribed: 5//2011		



(Required pursuant to R.C. 2119.123)

*		
Date RU-486 was provided:		31 2012
	Month	Day Year
2. Name of medical practice or fa	cility at which RU-486 was provide	d:
PLANNED PARENTHOO	B OF GREATER 6H1	o
3. Address of medical practice or 1 25350 ROCKSIDE R BEDFORD 1473, OH 1	O	ded:
4. Date post RU-486 event began		·
5. Event(s) (Please check all that a	арріу):	
Incomplete abortion	Adverse reaction to RU-486	Patient hospitalized
Patient received a transfusion	Severe bleeding	
Other serious event (specify)	French	
6. Duration of event:&	Hours 14 Days	
7. Remarks: TREATED WITH	PO ANTIBIOTICS X IV	() A() (
		nud2
:		
8. a. Name of physician who provid	led RU-486 DN David B	upicons, M.D.
8. b. Physician's signature	ATTIP	
o. o. r nysisian o signature	Date	(M.D./ D.O
Send completed forms to: S	tate Medical Board of Ohio	
	egal Department	MEDICAL BOARD
and the second s	0 E. Broad St., 3 rd Floor	
en e	olumbus, OH 43215-6127	JAN 8 4 2013
Prescribed: 5//2011	The second secon	

Report #30



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provided	:	August	30	2012
		Month	Day	Year
2. Name of medical practice of	or facility at wh	ich RU-486 was pro	ovided:	
Planned Parenthood	of Greate	r Ohio		
3. Address of medical practice	or facility at w	hich RU-486 was p	rovided:	
25350 Rockside Rd				
4. Date post RU-486 event beg	gan:			
9/15/2012				
5. Event(s) (Please check all the	nat 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:				
		4		
8. a. Name of physician who pr	ovided RU-48	6 David Burk	ons, MD	:
8. b. Physician's signature	Date		1/13	M.D / D.O
Cond completed forms				
Send completed forms to:		al Board of Ohio		
	Legal Depar		MEDIC/	AL BOARD
	30 E. Broad	St., 3 rd Floor		
	Columbus, (DH 43215-6127	14.5	\$ 4 2013

Report # 29

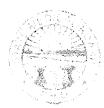


State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provided	d:	July	3	2012
		Month	Day	Year
2. Name of medical practice of	or facility at wi	hich RU-486 was	provided:	
Planned Parenthoo			•	
0.444				
3. Address of medical practice 25350 Rocksid	or facility at v eRd	which RU-486 was	s provided:	
Bedford Hts, o	H 44141	6		
4. Date post RU-486 event be	gan:			
7/19/2012				
5. Event(s) (Please check all ti	hat apply):			
Incomplete abortion	Advers	e reaction to RU-486	Patient	hospitalized
Patient received a transfusion	Severe	bleeding		
Other serious event (specify)				
6. Duration of event:	Hours	Days	:	
7. Remarks:				
;				·
B. a. Name of physician who pro	ovided Pt-48	6 David Bu	rkons, MD	
3. b. Physician's signature	Pate) // .//	413	M.D. / D.O
Send completed forms to:	State Medic	al Board of Ohio	**************************************	
	Legal Depar		<u> </u>	
		St., 3 rd Floor	WEDIC	ALBOARD
	Columbus, (OH 43215-6127		

Rynt#25



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provided:		2	28	12-
		Month	Day	Year
2. Name of medical practice or	facility at which	ch RU-486 was	provided:	
Planned Parenshor				
3. Address of medical practice	or facility at wh	nich RU-486 wa	us provided:	
25350 Rollende 1	~ .		ts 6H 441	46
4. Date post RU-486 event beg $\mathcal{U}/ \mathcal{Z} $ (an:	V		
5. Event(s) (Please check all the	at apply):			
✓ Incomplete abortion	Adverse	reaction to RU-48	6 Patient	hospitalized
Patient received a transfusion	Severe b	leeding	,	
Other serious event (specify)				
6. Duration of event:	_ Hours	Days		
7. Remarks:				
8. a. Name of physician who pro	vided RU-486	David 1	1 BUMONS	MD
3. b. Physician's signature	Date		4/19/12	M.D. / D.O
Send completed forms to:	State Medica	al Board of Ohio)	
	Legal Depart	ment		
	30 E. Broad	St., 3 rd Floor	MEDIO	ALBGARB Y 0 4 2012
	Columbus, C	H 43215-6127	MA	y 8 & 2012

Report#13

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

4 5 4 511 100			
1. Date RU-486 was provided:	3	\neg	2012
	Month	Day	Year
2. Name of medical practice or facility a	it which RU-486 was pro	vided:	
Planned Parenthood of	J Novmeast	Ohio	
3. Address of medical practice or facility	at which RU-486 was pi		
25350 Rockende Rd	Bed Ford H	ts OH	44146
4. Date post RU-486 event began:			
5. Event(s) (Please check all that apply):			
Ad	verse reaction to RU-486	Patient I	nospitalized
Patient received a transfusion Se	vere bleeding		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:			
8. a. Name of physician who provided RI	1486 Dand BUY	hons M	0
8. b. Physician's signature	Date 3/26//		M.D. / D.O
Send completed forms to: State M	edical Board of Ohio		
	epartment	e - Color	with body of
	oad St., 3 rd Floor		²⁹ - 5 2012
	us. OH 43215-6127		7



(Required pursuant to R.C. 2119,123)

1. Date RU-486 was provided	d:	66	07	2012
		Month	Day	Year
2. Name of medical practice of	or facility at whic	h RU-486 was	provided:	
PPNEO				
A Committee of the Comm				
3. Address of medical practice 25350 Rocks 100	or facility at whi	ich RU-486 wa	s provided:	
BEDFORD HEIGHT	3, OH 441	146		
4. Date post RU-486 event be			**************************************	
6-21-12				
5. Event(s) (Please check all t	hat apply):			
Incomplete abortion	Adverse r	eaction to RU-486	S Patien	it hospitalized
Patient received a transfusion	Severe bl	eeding		
Other serious event (specify) _		***************************************		
6. Duration of event:	Hours	IDays		
7. Remarks:				
			1	
8. a. Name of physician who p	rovided BU-486	Dr/BA	VID BUKK	45-
8. b. Physician's signature	TA	2//1	7.	M.D. / D.O
	Date	6/27	/DV	111.0.7 5.0
Send completed forms to:	State Medica	Board of Ohic)	
	Legal Departr	ment		
	30 E. Broad S	St., 3 rd Floor		EDIGAL BGARD
	Columbus, Ol	H 43215-6127		16.1 4 4 5019

(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provide	d:	5	8	2017
		Month	Day	Year
2. Name of medical practice	or facility at v	which RU-486 was pr	ovided:	
Planned Parenth				
3. Address of medical practice	e or facility at	t which RU-486 was _l	provided:	
25350 Rockend		Benford	HIS OH	44146
4. Date post RU-486 event be	[2	V		
5. Event(s) (Please check all t	that apply):			
Incomplete abortion	Adve	erse reaction to RU-486	Patier	nt hospitalized
Patient received a transfusion	Seve	re bleeding		
Other serious event (specify) _	of the second			
6. Duration of event:	Hours _	Days		
7. Remarks:				
8. a. Name of physician who p	rovided AU-	486 Mud Bu	rkons	No
8. b. Physician's signature 👍	11/			M.D. / D.O
	D D	ate	***	
Send completed forms to:	State Med	dical Board of Ohio		MEDICAL
	Legal Der	partment		MEDICAL BOARD
	30 E. Bro	ad St., 3 rd Floor		JUN 8 8 2012
	Columbus	s, OH 43215-6127		- Cur



(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provid	ded:	5	29	12
		Month	Day	Year
2. Name of medical practic	e or facility at v	vhich RU-486 was	provided:	
PPNEO				
3. Address of medical pract	ico or facility of	which DU 400		
3. Address of medical pract \$25350 ROULSIDE N	C)	wnich HU-486 wa	s provided:	
BEDFORD HTS, OH				
4. Date post RU-486 event I	began:			
5. Event(s) (Please check a	ll that apply):			
Incomplete abortion	Adver	se reaction to RU-486	Patient h	nospitalized
Patient received a transfusion	Sever	e bleeding		
Other serious event (specify)				
6. Duration of event:	Hours	Ø Days		
7. Remarks:				
. a. Name of physician who	provided RU	186 Ar Adlia	Augusto	
. b. Physician's signature	100	Se BAVIB	L-	M.D. / D.O
	Øa	te	/	IVI.U. / U.U
end completed forms to:	State Medi	cal Board of Ohio	3	
	Legal Depa		MEDICA	LBOARD
	30 E. Broa	d St., 3 rd Floor	JUN 1	
	Columbus.	OH 43215-6127		n talk



(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provided:	05	17	2012
	Month	Day	Year
2. Name of medical practice or facility PPNEO	ty at which RU-486 was pr	rovided:	
3. Address of medical practice or faci 25350 Nockside RN BEDFORD HEIGHTS, OH 44		provided;	
. Date post RU-486 event began: しーしー12			
. Event(s) (Please check all that app	ly):		
Incomplete abortion	Adverse reaction to RU-486	Patient	hospitalized
Patient received a transfusion	Severe bleeding		
Other serious event (specify)			
Duration of event: Hou	rs Days		
Remarks:		MEDIC	AL BOARD
			13 2012
a Name of physician what			
a. Name of physician who provided	14U-48 DAVID BUI	LKENS, MD	
b. Physician's signature	Date //		M.D. / D.C
nd completed forms to: State	Medical Board of Ohio		
	Department		
	Broad St., 3 rd Floor		
	1bus OH 43215-6127		



(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provided			
1. Date 110-400 was provided		01	2011
	Month	Day	Year
2. Name of medical practice of	r facility at which RU-486 was p	rovided:	
PPNEO			
3. Address of medical practice	or facility at which RU-486 was	provided:	
19530 ROCKSIDE	RD, BEDFORD, OH	44146	
4. Date post RU-486 event beg	gan:		
12/15/11			
5. Event(s) (Please check all the	nat apply):		
Incomplete abortion	Adverse reaction to RU-486	Patient	hospitalized
			Troophanaoa
Patient received a transfusion	Severe bleeding		
	•		
Other serious event (specify)	HOMATOM PTICA evror		
		77144	
6. Duration of event: 9	Hours 12 Davis	30. 1	
o. Bulation of event,	nours Days		
7.0			
7. Remarks:			
	1		
	A		
8. a. Name of physician who pro	prider Ry-486 <u>Jr. DAV</u>	O BURKON.	۷
8. b. Physician's signature	XIII -tt		,M,D. / D.O
	Date 5/4/)	
Conditional			
Send completed forms to:	State Medical Board of Ohio		
	Legal Department		
S1:2 HJ ==	30 E. Broad St., 3 rd Floor	E & Freez Broke &	A 0.4 m.
2012 HAY 29 PH 2: 15	Columbus, OH 43215-6127	WED	CAL BOARD
ORANG JANO TO STATE MEDICAL SOLUTION OF STATE MEDICAL STATES		W.	Y 29 2012
Prescribed: 5//2011			. « A COIC

Rept #8



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provide	ed:	01	19	2012
		Month	Day	Year
2. Name of medical practice	or facility at w	hich RU-486 was pi	rovided:	real
3. Address of medical practic	o or facility of	which DII 400		
3. Address of medical practic	e or racility at v	wnich MU-486 was	provided:	
19550 ROUKSID	E RD.	BEDI		
4. Date post RU-486 event b	egan:			
	2/17/12			
5. Event(s) (Please check all	that apply):			***************************************
Incomplete abortion	Advers	e reaction to RU-486	Patient h	nospitalized
Patient received a transfusion	Severe	bleeding		
Other serious event (specify)				
6. Duration of event:	Hours	<u></u> ∆ Days		
7. Remarks: It nev	n reli	and for F	=/4 &r	dmt Anva
3. a. Name of physician who p	ro∜ided RU-48	36 DR. DAVID	BURKONS	
B. b. Physician's signature _	-//-	11		M.D./ D.O
	Dat	6 5/11//)	
Send completed forms to:	State Medic	cal Board of Ohio		
	Legal Depa			
SI:S MA 85 YAM 210S		St., 3 rd Floor		
UNAGO DIHO HO		OH 43215-6127	MEDI	CALBOARD
STATE MEDICAL BOARD OF OHIO			WZ	Y 29 2012

Pept#5



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provided:		W	21	
		Month	Day	Year
2. Name of medical practice or	acility at which	h, RU-486 was p	provided:	
Planned Parenth	nd gr	Jomean	- OMO_	
3. Address of medical practice o	r facility at wh	ich RU-486 was	provided:	
1960 Rolling	e Rd	Bedford	OH 4414	16
4. Date post RU-486 event bega	n:			
5. Event(s) (Please check all tha	t apply):			
✓ Incomplete abortion	Adverse	reaction to RU-486	Patient h	nospitalized
Patient received a transfusion	Severe b	leeding		
Other serious event (specify)				
6. Duration of event:	Hours	Days		
7. Remarks: DAC for pe	rsistent	Sae		
8. a. Name of physician who prov	ided RU-486	FLAMA BY	nears M	D
8. b. Physician's signature	XM	1		M.D. / D.O
Send completed forms to:		al Board of Ohio		
	Legal Depart			
		St., 3/6 Filpopild (7015 TVH 36	
	Columbus, C	DH 43215-6127		
		oayoa Yib	Mana s	

V Ript#3



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provided:		July	12	2011
		Month	Day	Year
2. Name of medical practice or f	acility at which	RU-486 was pr	ovided:	
Planned F	Parenthood	of Nov	theast OH	110
3. Address of medical practice or	r facility at whic	h RU-486 was i	provided:	
19550 ROCKSIde R	ed Bed	ford, OH	44146	
4. Date post RU-486 event bega	. 1			
5. Event(s) (Please check all that	t apply):			
Incomplete abortion	/	action to RU-486	Patient ho	ospitalized
Patient received a transfusion	Severe blee	eding		
Other serious event (specify)				
6. Duration of event: 35	Hours			
7. Remarks:				
······································				
		_		
8. a. Name of physician who prov	ided \$486	Dand B	surkons N	10
	aNI	1	,, ///	
8. b. Physician's signature	Date_	9/2/11	3	M.D. / D.O
Send completed forms to:	State Medical	Board of Objo		
Cond completed tetrid to.	Legal Departm			
	30 E. Broad S		• , •	:
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Columbus, OH 43215-6127				
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