

# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provided:	Sent	18 2012
	Month	Day Year
2. Name of medical practice or fa	cility at which RU-486 was provide	ed:
Planned Parenthe		
The state of the orthogonal	4 51 CHOCKS CALLS	
3. Address of medical practice or t	acility at which RU-486 was provide	ded:
	, Bedford Hts, OH 4	
	, 53, 15, 21	1110
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	
	r	
Other serious event (specify)		
6. Duration of event:	lours Days	
	Days	
7. Remarks:		
7. Hemarks;		
	,	
8. a. Name of physician who provide	190 RU-486 Sarah Smit	h, MD
8. b. Physician's signature		M.D. / D.O
	pare 1/15/13	
<u> </u>	Vale :110 1:3	
Send completed forms to:	tate Medical Board of Ohio	
Ļ	egal Department	
3	D E. Broad St., 3 <sup>rd</sup> Floor	MEDICAL BOARD
PRINCE	olumbus, OH 43215-6127	JAN 24 2013
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Prescribed: 5//2011	·	
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Riport #97

## State Medical Board of Ohio Report of RU-486 Event MEDICAL BUARD

(Required pursuant to R.C. 2119.123)

SEP 1 0 2012

1. Date RU-486 was provided:	June	12	2012
_	Month	Day	Year
2. Name of medical practice or facility at which	RU-486 was pro	vided:	T. T
Planned Parenmood of Nov			
1 constant to sold troop of 1400	Theon On	10	
3. Address of medical practice or facility at which	ch RU-486 was pr	ovided:	
25350 Rochende Po	·		
Bedford Hts, Olt			
4. Date post RU-486 event began:			
E/29/12			
5. Event(s) (Please check all that apply):			
/ Incomplete charties		<b>.</b>	
Incomplete abortion Adverse re	action to RU-486	Patient hos	epitalized
Patient received a transfusion Severe ble	adina		
Severe ble	ealing		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:			
8. a. Name of physician who provided RU-486	GAVALA V	CMIHA 1	UD
· / X /////	John College	Siver	
8. b. Physician's signature	QI.I.		M.D.// D.O
Date_	9/4/12	<u> </u>	
Send completed forms to: State Medical	Board of Ohio		
Legal Departn	nent		
30 E. Broad S			
Columbus, Oh			
Columbus, Or	1 40210-012/		

Report #26



### State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provide	d:	3	13	2012
		Month	Day	Year
2. Name of medical practice	or facility at whic	h RU-486 was	provided:	<del></del>
Planned Parenth	rod of N	orheags	Orio	
3. Address of medical practice 25350 focuse de Bedford Hts C	Rd H 44146		s provided:	
4. Date post RU-486 event be	4/5/12			
5. Event(s) (Please check all	hat apply):			Andreas and a second and a second *
Incomplete abortion	Adverse r	reaction to RU-486	6 Patlen	t hospitalized
Patient received a transfusion	Severe bl	eeding		
Other serious event (specify) _				-
6. Duration of event:	Hours	Days		
7. Remarks:				
8. a. Name of physician who p	rovided RU-486	Savolh k	Smith	MD
8. b. Physician's signature _	Date	9 5/1/1	12	M.D. / D.O
Send completed forms to:	Legal Departi 30 E. Broad S			MEDIGAL BUARD

Report # 24



## State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provided:		3	27	2012
		Month	Day	Year
2. Name of medical practice or fa	cility at	which RU-486 was pr	ovided:	
Planned Parentnoo	d of	Normant	Ohio	
3. Address of medical practice or	facility a	t which RU-486 was r	provided:	
25350 Rockende Ro Beaford Hts OH	! !4146	7	ordinada.	
4. Date post RU-486 event began		1/12		
5. Event(s) (Please check all that	apply):			######################################
Incomplete abortion	Adve	erse reaction to RU-486	Patient	hospitalized
Patient received a transfusion	Seve	ere bleeding		
Other serious event (specify)	***************************************	and the second s	201.00	
6. Duration of event:	Hours _	Days		
7. Remarks:				
T. Homand.				
8. a. Name of physician who provi	ded/RU	-486 <u>Sarah</u>	K Shut	n MD
8. b. Physician's signature	/////	1	,	(M.D.)/ D.O
9		Pate 4/24	1/2	
Send completed forms to:	state Me	dical Board of Ohio	——————————————————————————————————————	
L	egal De	partment		
3	0 E. Bro	oad St., 3 <sup>rd</sup> Floor	الله المناجين التيميان	aar aaaaan
		s, OH 43215-6127	Medi	GAL BOARD
			J.	v 0 4 2012

Report # 32



#### State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provide	ed:	3	60	2012
		Month	Day	Year
2. Name of medical practice	or facility at whi	ch RU-486 was p	rovided:	
Planned Parent	rood of	Northear.	+ Ohio	
O Address of the little of the				
3. Address of medical practic	_			
25350 Rockende	Rd Be	d ford Hts 1	OH 4414	(φ
4. Date post RU-486 event be	•			
3/201	12			
5. Event(s) (Please check all	that apply):			MANAGEMENT IN THE STATE OF THE
Incomplete abortion	Adverse	reaction to RU-486	Patient	hospitalized
Patient received a transfusion	Severe b	eleeding		
Other serious event (specify)				***************************************
6. Duration of event:/	Hours	Days		
7. Remarks:	***************************************			
8. a. Name of physician who p	provided \RU-486	Sarah K S	Smith M	D
8. b. Physician's signature _	( X/ ( / (	) <u>V</u>		MD /DO
	Date	3/27	/12-	M.D. / D.O
01				
Send completed forms to:		al Board of Ohio	MEns	The second second
	Legal Depart		《芦苇花丛影通書書	SAL SCARD
i :	30 E. Broad		ΔP	8 5015
<u>:</u> :	Columbus, C	)H 43215-6127		4 - A 1 € Co.

· Report # 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 provide	q.	<i>(</i> )- <i>(</i>	C L	2011
		Month		Year
2. Name of medical practice	or facility at	which RU-486 was p	rovided:	
Planned Parents	rood of	y Northeast	Ohro	
3. Address of medical practic	e or facility a	t which RU-486 was	provided:	
19550 Rockside	e Rd	Bedfor	d OH	44146
4. Date post RU-486 event be	egan: 0/21/11			
5. Event(s) (Please check all	that apply):			
Incomplete abortion	Adve	erse reaction to RU-486	Patier	nt hospitalized
Patient received a transfusion	Seve	ere bleeding		
Other serious event (specify)				
6. Duration of event:	Hours _	Days		
7. Remarks: in-clinic for	, elleton failed,	performed v wedawhip aba	vithout C	omplication
8. a. Name of physician who p 8. b. Physician's signature _	provided RU	-486	WE/11	) (M.D.) D.O
Send completed forms to:	State Me	dical Board of Ohio		
	Legal De	partment		
	30 E. Bro	oad St., 3 <sup>rd</sup> Floor		
	Columbu	s, OH 43215-6127	į ži į	EDICAL BOARD
				NUV 1 4 2011

Prescribed: 5/--/2011

Rpt#16



## State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

4 5 1 5 1 1 1 1 1 1 1 1				
Date RU-486 was provided	d:	11	10	2011
		Month	Day	Year
2. Name of medical practice	or facility at which	h RU-486 was	s provided:	
PPNEO				
3. Address of medical practice	or facility at whi	ch RU-486 wa	as provided:	
19550 ROCKS			D, OH 4	4146
4. Date post RU-486 event be	12/3	/11		
5. Event(s) (Please check all t	hat apply):			
Incomplete abortion	Adverse re	eaction to RU-48	6 Patient	hospitalized
Patient received a transfusion	Severe ble	eding		
Other serious event (specify)	HEMATOME	TRA		
3. Duration of event:	Hours	<sup>发</sup> Days		
7. Remarks:				
	Λ .			
a. Name of physician who py	Ovided/RIJ-486	Dr. S	MLAH SMIT	H
. b. Physician's signature	X	7/	1	
	Date_	6/2	12.	(M.D)/ D.O
end completed forms to:	State Medical I	Board of Ohio	3	ACDIOAL DOLL
	Legal Departm		Combine	MEDICAL BOARD
	30 E. Broad St			JUN 19 2012
paramen.	Columbus, OH			- Marie II Albert



# State Medical Board of Onio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provided	d:	10	4	2011
	·	Month	Day	Year
2. Name of medical practice of PFN FO	or facility at which	າ RU-486 was	provided:	
3. Address of medical practice	or facility at whi	ch RU-486 war	s provided:	
19550 Rocks				44146
4. Date post RU-486 event be l○/∫√//II	_			
<ol><li>Event(s) (Please check all ti</li></ol>	nat apply):			
Incomplete abortion	Adverse re	eaction to RU-486	Patier	nt hospitalized
Patient received a transfusion	Severe ble	eding		
Other serious event (specify)	HEMATOM	ETMA		
3. Duration of event:1	HoursØ	Days		
7. Remarks:				
-				
. a. Name of physician who pro	ovided RU-486	An. St	TRAH SM	ITH
. b. Physician's signature	Date_	U5)	Mr	M.D. / D.O
end completed forms to:	State Medical I	Board of Ohio	-	
2012 MAY 29 PM 2: 15	Legal Departm 30 E. Broad St.	ent		NCAL BOARD
STATE MEDICAL BOARD	Columbus, OH			AA 88 SOIS

Rept# 10



## State Medical Board of Grio 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 provid	ded:	11	01	2011
		Month	Day	Year
2. Name of medical practice	ce or facility at whi	ch RU-486 was p	rovided:	
3. Address of medical pract	tice or facility at wh	nich RU-486 was	provided:	
19550 Rock	SIDE RO,	BEDFORD,	oH 441	46
4. Date post RU-486 event	began:	:		
5. Event(s) (Please check a	all that apply):			
Incomplete abortion	Adverse	reaction to RU-486	Patient	hospitalized
Patient received a transfusion	n Severe b	leeding		
Other serious event (specify)  6. Duration of event:		<b>⊅</b> Days		
7. Remarks:				
8. a. Name of physician who	provided RU-486	3/DR. Sma	MH SMITT	1
8. b. Physician's signature	Date	11 5/	128/12	M.D. / D
Send completed forms to:	State Medica	al Board of Ohio	-	
Nd 62	Legal Depart			
STATE MEDICAL OF OHIO 2012 MAY 29 PM S	30 E. Broad Columbus, C	St., 3 <sup>rd</sup> Floor 9H 43215-6127	MEDIC	ALBOARD
STATE MENI				28 5015

Prescribed: 5/--/2011

Rept#4



#### State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provided:	17/	9	11
	Month	Day	Year
2. Name of medical practice or facility	at which RU-486 was r	provided:	
Planned Parenthood	1 of Namues	- 811-	
partition ( total of the total	J Horneast	UH	-
3. Address of medical practice or facility	ty at which RU-486 was	provided:	
19950 Rollende 1	ed Bidfo	vd off 4	14146
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: Hour	s Days		
7. Remarks:			
	0 1 0		
8. a. Name of physician who provided	RU-486/ 10/6	h KJMIN	L/W)
8. b. Physician's signature	/ / / / / /	1 ,1	/ M.D. / D.O
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	Medical Board of Ohio		
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