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

MEDICAL BOARD
MAY 31 2012

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:
3755 E. MAIN STREET Lou'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 Kader

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 5-1/2011

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

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MAY 21 2012

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STATE MEDICAL BOARD OF OHIO

Prescribed: 5/--/2011