

report #4

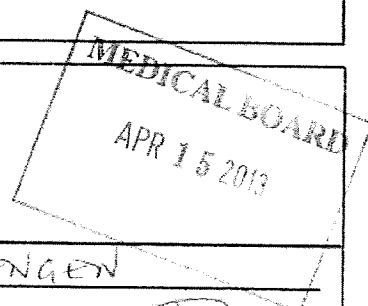


# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>2</u>	<u>26</u>	<u>2013</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>PLANNED PARENTHOOD OF GREATER OHIO</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>25350 ROCKSIDE RD, BEDFORD HTS, OH 44146</u>			
4. Date post RU-486 event began: <u>3-14-13</u>			
5. Event(s) (Please check all that apply):			
<input checked="" type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized	
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding		
<input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>&lt; 1</u> Hours <u>6</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>DR SARAH LENGEN</u>			
8. b. Physician's signature <u>[Signature]</u>			<u>M.D. / D.O.</u>
Date <u>4/9/13</u>			



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

Report # 40



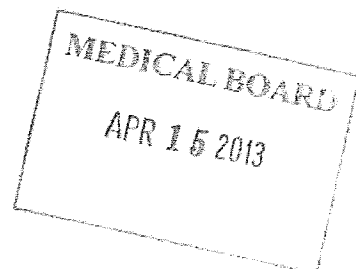
# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>2</u> Month	<u>5</u> Day	<u>2013</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>PLANNED PARENTHOOD OF GREATER OHIO</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>25350 ROCKSIDE RD, BEDFORD HTS, OH 44146</u>			
4. Date post RU-486 event began: <u>2-22-13</u>			
5. Event(s) (Please check all that apply):			
<input checked="" type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized	
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding		
<input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>&lt; 1</u> Hours <u>0</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>DR SARAH LINGEN</u>			
8. b. Physician's signature <u>[Signature]</u>		<input checked="" type="checkbox"/> M.D. / D.O.	
		Date <u>4/9/13</u>	

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report # 39

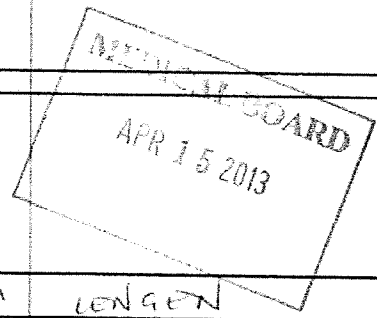


# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
2	19	13
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 ADELPHI RD, BEAVER CREEK, OH 44146		
4. Date post RU-486 event began: 3/9/13		
5. Event(s) (Please check all that apply):		
<input checked="" type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding	
<input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: <u>0</u> Hours <u>1</u> Days		
7. Remarks:		
8. a. Name of physician who provided RU-486: DR JARNA LONGEN		
8. b. Physician's signature		M.D. / D.O.
Date		4/9/13



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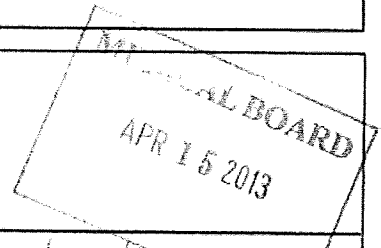


# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
7	17	12
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 RECKSIDE RD, BEDFORD HTS, OH 44146		
4. Date post RU-486 event began:		
5. Event(s) (Please check all that apply):		
<input checked="" type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding	
<input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: <u>21</u> Hours <u>0</u> Days		
7. Remarks:		
8. a. Name of physician who provided RU-486 <u>DR SARAH LUTGEN</u>		
8. b. Physician's signature <u>[Signature]</u>		M.D./D.O.
Date <u>4/9/13</u>		



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