Suport #97



State Medical Board of Ohio Report of RU-486 EventMEDICAL BUARD

(Required pursuant to R.C. 2119.123)

SEP 1 0 2012

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		dune	12	2012
		Month	Day	Year
2. Name of medical practice or formula Parameters of the Parameter				
3. Address of medical practice or 35360 Rockinde A Bedford #1514. Date post FU-486 event began	BH -	ch RU-486 was _l	provided:	
Color Positive Tool Section Se	ralin			
5. Event(s) (Please check all that	t apply):			
Incomplete abortion	Adverse re	eaction to RU-486	Patient h	ospitalized
Patient received a transfusion	Severe ble	eeding		
Other serious event (specify)				
6. Duration of event:	Hours	Days		
7. Remarks:				
8. a. Name of physician who proy	vided RU 486	Savahk	Smith	MO
8. b. Physician's signature	Date.	9/4/	2	M.D.// D.O
Send completed forms to:	State Medica	l Board of Ohio		
	Legal Depart			
	30 E. Broad	St., 3 rd Floor		

Columbus, OH 43215-6127



(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provide	d:	66	07	2012
		Month	Day	Year
2. Name of medical practice	or facility at w	hich RU-486 was	provided:	
3. Address of medical practice 25350 ROCKS, D BEDFORD HEIGH	e No		s provided:	
4. Date post RU-486 event be 6-21-12		77.4		
5. Event(s) (Please check all	that apply):			
Incomplete abortion	Adver	se reaction to RU-486	Patien	t hospitalized
Patlent received a transfusion	Sever	e bleeding		
Other serious event (specify)				-
6. Duration of event:	Mours			
7. Remarks:				
			1	
8. a. Name of physician who	provided BU-	186 DR/BA	VID BULL	13-
8. b. Physician's signature .		ne 6/27	The	M.D. / D.O
Send completed forms to:	State Med	lical Board of Ohio)	
	Legal Dep			
	30 E. Broa	ad St., 3 rd Floor	ME	EDIGAL BOARD
· · · · · · · · · · · · · · · · · · ·	Columbus	, OH 43215-6127	7	JUL 0 9 2812

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:		.1.	9	4.1
paid the tree made promises.		Month	Day	Year
Name of medical practice or	facility at wh			real
TOTAL : (1000년 전 100명 2007) 이렇게 (100명 100명) (100명 100명 100명 100명 100명 100명 100명 100				
Planned Parent	rivo a	Novtheas	4 OH	
3. Address of medical practice of	or facility at v	which RU-486 wa	s provided:	and the second s
19950 Rower				44146
4. Date post RU-486 event beg	an:			
5. Event(s) (Please check all the	at apply):			
Incomplete abortion	Advers	se reaction to RU-48	6 Patient	thospitalized
Patient received a transfusion	Severe	e bleeding		
Other serious event (specify)				
6. Duration of event: 2	Hours	Days		
7. Remarks:				
0 - N		10h 10h0	dak faul	1 11/
8. a. Name of physician who pro	ovided HU-4	186 7 (4)	MIN STATE	7700
8. b. Physician's signature	$\overline{}$		1 01/1/10	M.D. / D.O
	Da	ite	1/24/12	
Send completed forms to:	State Med	lical Board of Ohi	0	
	Legal Dep			
		addst. D3 4 Floor 07		
		, OH 43215-612		
	OHAOS	The state of the s	C	

Rept #5



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provide	d:	W	21	
		Month	Day	Year
2. Name of medical practice				
Planned Parent	hood of r	Jonneas.	+ OMD	
3. Address of medical practic	e or facility at wh	nich RU-486 wa	s provided:	
1960 Rollen	le Pd	Bedford	at 4414	4
4. Date post RU-486 event be	egan:			
5. Event(s) (Please check all	that apply):			
✓ Incomplete abortion	Adverse	reaction to RU-486	Patient h	ospitalized
Patient received a transfusion	Severe b	leeding		
Other serious event (specify)				
6. Duration of event:2	Hours	Days		
7. Remarks: DSC For	Denseut	SAP		
199C 101	POLITICION	and a		
8. a. Name of physician who	provided RU-48	DAMA BI	means M	.D
8. b. Physician's signature	1811	7		M.D. / D.O
· · · · · · · · · · · · · · · · ·	Date	/	nely	IVI.D. 7 D.O
Send completed forms to:	State Medica	al Board of Ohio)	
	Legal Depar	tment		
	30 E. Broad	St., 3/6 Flpqid	2012 JAN 30	
		OH 43215-6127		
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(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided	i:	-	8	
		Month	Day	2012
2. Name of medical practice	or facility at v			1601
Planned Parenth		The second secon		
3. Address of medical practice	or facility at	which RU-486 was p	provided:	
26350 Rocherd	e Rd	Berford	HE OH	44146
4. Date post RU-486 event be $ Q $ $ G $	gan:	U		
5. Event(s) (Please check all t	hat apply):			
Incomplete abortion	Adve	erse reaction to RU-486	Patient	hospitalized
Patient received a transfusion	Seve	ere bleeding		
Other serious event (specify) _				
6. Duration of event:	Hours _	Days		
7. Remarks:		//		
	\/			
8. a. Name of physician who p	rovided RU	-486 Sand Br	Irkons M	10
8. b. Physician's signature	111			M.D. / D.O
U		Date		
Send completed forms to:	State Me	dical Board of Ohio	A	MEDION:
	Legal De	partment		MEDIGAL BOARE
	30 E. Bro	oad St., 3 rd Floor		JUN 28 2012

Columbus, OH 43215-6127

Rpt#16



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provided	l:	1)	10	2011
		Month	Day	Year
2. Name of medical practice of	or facility at which	RU-486 was p	rovided:	
PPNEO				
3. Address of medical practice	or facility at which	h RU-486 was	provided:	
19550 ROCKS,	DE RO,	BEDFORD	04 4	4146
4. Date post RU-486 event be	gan: 12/3	/n		
5. Event(s) (Please check all t	hat apply):			
Incomplete abortion	Adverse re	action to RU-486	Patien	t hospitalized
Patient received a transfusion	Severe ble	eding		
Other serious event (specify) _	HEMATOME	TRA		
6. Duration of event:	Hours	Days		
7. Remarks:				
	Λ			
8. a. Name of physician who p	ovided/RIJ-486	DR. SI	AMAH SMI	ਜ
8. b. Physician's signature	Date_	6/2/	8.	M.D/ D.O
Send completed forms to:	State Medical Legal Departn	Board of Ohio		MEDICAL BOAR
	30 E. Broad S			JUN 19 2012
	Columbus, Ol			



(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provided	: 5	29	12
	Month	Day	Year
2. Name of medical practice of PPNEの	or facility at which RU-486 wa	as provided:	
3. Address of medical practice 25350 ROULSIDE RD		vas provided:	
4. Date post RU-486 event be			
5. Event(s) (Please check all t	hat apply):		
Incomplete abortion	Adverse reaction to RU-4	186 Patient	hospitalized
Patient received a transfusion	Severe bleeding		
Other serious event (specify) _			
6. Duration of event:	HoursØDays		
7. Remarks;			
8. a. Name of physician who p 8. b. Physician's signature _	provided RU486 Dr. DAVI	D BURKONS	M.D. / D.O
Send completed forms to:	State Medical Board of O Legal Department 30 E. Broad St., 3 rd Floor	MEDIC JUN	AL BOARD 1 8 2012

rept# 13



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provided:	0.5	17	2012
	Month	Day	Year
2. Name of medical practice or face	ility at which RU-486 was pro	ovided:	
3. Address of medical practice or fa 25350 NOCKSIDE RD BEDFORD HEIGHTS, OH		provided:	
4. Date post RU-486 event began: しゅーしー12			
5. Event(s) (Please check all that a	pply):		
Incomplete abortion	Adverse reaction to RU-486	Patient	hospitalized
Patient received a transfusion	Severe bleeding		
Other serious event (specify)			
6. Duration of event:	lours Days		
7. Remarks:			CAL BOARD N 1 3 2012
8. a. Name of physician who previo	Date (nkans, M	۵ M.D. / D.O
Send completed forms to: S	itate Medical Board of Ohio		
L	egal Department		
3	0 E. Broad St., 3 rd Floor		
C	columbus, OH 43215-6127		

Rept # 12

Prescribed: 5/-/2011

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provide	d: 4	4	LOA
	Month	Day	Year
	or facility at which RU-486 wa	s provided:	
(rentral Di	hid Women's	Center	
3. Address of medical practic	e or facility at which RU-486 w	vas provided:	
3155 E. M	ain Street Coll	un bus Olio	43213
4. Date post RU-486 event be	egan: 4-12-12		
5. Event(s) (Please check all	that apply):		
	Adverse reaction to RU-4	986 Patient hos	spitalized
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 p	provided RU-486)	
8. b. Physician's signature	MALY	Mayer MS	M.D. / D.O
	Date	1 3/84/-	•
Send completed forms to:	State Medical Board of Ol	hio	
	Legal Department		
	30 E. Broad St., 3 rd Floor Columbus, OH 43215-61	27 ME	DIGAL BOAR
			MAY 21
Dranginal El Mass			JA 2012



(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provided:		10	4	2011
	_	Month	Day	Year
2. Name of medical practice or PfN EO	facility at which	RU-486 was pi	rovided:	
3. Address of medical practice of	or facility at whic	h RU-486 was	provided:	
19550 Rocks1				44146
4. Date post RU-486 event beg	an:			
5. Event(s) (Please check all the	at apply):			
Incomplete abortion	Adverse rea	action to RU-486	Patien	t hospitalized
Patient received a transfusion	Severe blee	eding		
Other serious event (specify)	HEMATOM	ETMA		
6. Duration of event:1	_ HoursØ	Days		
7. Remarks:				,
8. a. Name of physician who pro	ovided PII-496	Dr. SA	TRAH SM	1771
8. b. Physician's signature	Date_	0 /	Mr	M.D. / D.O
Send completed forms to:	State Medical	Board of Ohio		
ZI :S M9 ES YAM SIOS	Legal Departm 30 E. Broad S		MEL	DICAL BOARD
STATE MEDICAL BOARD	Columbus, Ol-	1 43215-6127		MAY 29 2012

Rept#10



State Medical Board of Gio 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	d:	11	01	2011
		Month	Day	Year
2. Name of medical practice	or facility at w	hich RU-486 was	provided:	
PPNEO				
3. Address of medical practic	e or facility at	which RU-486 wa	s provided:	
19550 Rocksi	DE Ro.	BEDFORD,	oH 441	46
4. Date post RU-486 event be	egan:			
5. Event(s) (Please check all	that apply):			
Incomplete abortion	Advo	se reaction to RU-480	6 Patient	noonitalized
- moonipiete adortion	Adver	se reaction to no-480	6 Patient	nospitalized
Patient received a transfusion	Sever	e bleedina		
Other serious event (specify)				
Outer serious event (specify)				
6. Duration of event:	Центо	₩ Dave		
o. Duration of event.	Hours	Days		
7 Demodes				
7. Remarks:				
8. a. Name of physician who	provided BII	Ade /IND CA	MAH SMITT	1
	/ V	10/11/11/11	1 1	
8. b. Physician's signature	1500	III. E	122/12	M.D. / D
	D	ate2	10011	
Send completed forms to:	State Med	dical Board of Ohio	0	
2.4.	Legal Der	pariment		
Hd co.	Legal Dep 30 E. Bro			
STATE MEDICAL OF OHIO SOLZHAY 29 PM S	30 E. Bro	partment ad St., 3 rd Floor s, OH 43215-6127	MEDIC	CAL BOARD

Prescribed: 5/--/2011

Prescribed: 5/--/2011



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provided:	12	01	2011
	Month	Day	Year
2. Name of medical practice or f	acility at which RU-486 was	provided:	
3. Address of medical practice or	r facility at which RU-486 wa	as provided:	
19550 ROCKSIDE	RD, BEDFORD, OH	44146	
4. Date post RU-486 event bega			
5. Event(s) (Please check all that	t apply):		
Incomplete abortion	Adverse reaction to RU-48	6 Patier	nt hospitalized
Patient received a transfusion	Severe bleeding		
Other serious event (specify)	lengion en RA en	or	
6. Duration of event:	Hours13_ Days		
7. Remarks:			
	\mathcal{M}		
8. a. Name of physician who prov	video Ry-486 Jr. Dr	tio Burko	NS
8. b. Physician's signature	Date 5/4/	5	M,D. / D.O
Send completed forms to:	State Medical Board of Ohi Legal Department	lo	
2012 MAY 29 PM 2: 15	30 E. Broad St., 3 rd Floor Columbus, OH 43215-612	, ME[DICAL BOARD
OAAOB JASSES			MAY 29 2012

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	19	2012
		Month	Day	Year
2. Name of medical practice of	r facility at v	vhich RU-486 was p	provided:	
3. Address of medical practice	or facility at	which RU-486 was	provided:	
19550 ROUKSIDE	E RO.	BEDI		
4. Date post RU-486 event beç	gan: ² /17/1	2		
5. Event(s) (Please check all the	nat apply):			
Incomplete abortion	Adve	rse reaction to RU-486	Patien	t hospitalized
Patient received a transfusion	Seve	ere bleeding		
Other serious event (specify)				
6. Duration of event:	Hours	∑ Days		
7. Remarks: The new second less than the consideration of the considera	n rej	lund for	F/4 80	dmt snow
8. a. Name of physician who p	royided RU	-486 DR. DAVID	Burkons	
8. b. Physician's signature _	\mathcal{A}	Parte 5/1//	7	M.D./I D.O
Send completed forms to:	State Me	dical Board of Ohio		
	Legal De	partment		
2012 HAY 29 PM 2: 15		oad St., 3 rd Floor	4.00	DIOAL DOADS
STATE MEDICAL BOARD	Columbu	s, OH 43215-6127	ME	DICAL BOARD MAY 29 2012

Prescribed: 5/--/2011

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 which	ch RU-486 was	provided:	
Planned Parenthe	rod of N	orheast	Ohio	
3. Address of medical practice 25350 Rocus de Bedford Hts 0	Rd		s provided:	
4. Date post RU-486 event be				
5. Event(s) (Please check all	that apply):			
Incomplete abortion	Adverse	reaction to RU-48	6 Patie	nt 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 p	provided RU-48	6 Sarah	c Smith	MD
8. b. Physician's signature _	Date	Q 3/1/1	12	M.D. / D.O
Send completed forms to:	State Medic	al Board of Ohi	0	
	Legal Depar	tment		MEDIGAL BOAR
		St., 3 rd Floor		WEDION 0 4 5015
	Columbus, 0	OH 43215-612	7	MAY O 4 ZUIZ

Report# 25



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provide	d:	2	29	12/	
		Month	Day	Year	
2. Name of medical practice	or facility at wh	nich RU-486 was	provided:		
Planned Parens					
3. Address of medical practic	e or facility at v	which RU-486 wa	as provided:		
25350 Rochende	Rd	Bedford H	ts 6H 441	46	
4. Date post RU-486 event be $U/3$		V			
5. Event(s) (Please check all	that apply):				
✓ Incomplete abortion	Advers	se reaction to RU-48	6 Patient	hospitalized	
Patient received a transfusion	Severe	bleeding			
Other serious event (specify)					
6. Duration of event:	Hours	Days			
7. Remarks:					
T T TO THAT TO		1			
8. a. Name of physician who	provided RU	86 David	U Brmon	s MD	
8. b. Physician's signature	1//			M.D. / D.O	
,	Da	te	4/19/12	111.5.7 5.0	
Send completed forms to:	State Med	ical Board of Ohi	0		
	Legal Department				
		d St., 3 rd Floor	MEBI	GALBGARB	
	Columbus	OH 43215-612	7 M	AY 0 4 2012	

Report # 24



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	21	2012		
		Month	Day	Year		
2. Name of medical practice	or facility at wh	nich RU-486 was p	rovided:			
Planned Parents	road of	Normeast	Ohio			
3. Address of medical practic	e or facility at w	which RU-486 was	provided:			
25350 Rockende Beaford Hts OH						
4. Date post RU-486 event be		12				
5. Event(s) (Please check all	that apply):					
Incomplete abortion	Advers	e reaction to RU-486	Patien	t 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-4	86 Sarah	K Shu;	to MD		
8. b. Physician's signature	X///00			(M.D)/ D.O		
o. b. r nysician's signature	Da	in Whe	1/12	(WI.U) U.O		
0 1 1 1 1 1 1 1		110	41-			
Send completed forms to:		ical Board of Ohio				
	Legal Depa					
		E. Broad St., 3rd Floor MEDIGAL BO				
	Columbus,	OH 43215-6127				
				MAY 0 4 2012		



(Required pursuant to R.C. 2119.123)

1. Date RU-486 was provided	1:	3	1	2012
		Month	Day	Year
2. Name of medical practice of	or facility at v	vhich RU-486 was pro	vided:	
Planned Parenth	nod of	Novmeast	Olio	
3. Address of medical practice	or facility at	which RU-486 was p	rovided:	
25350 Rockende	Rd	Bed ford H	HS OH	44146
4. Date post RU-486 event be 3/20/12	gan:			
5. Event(s) (Please check all t	hat apply):			
Incomplete abortion	Adve	erse reaction to RU-486	Patient	hospitalized
Patient received a transfusion	Seve	ere bleeding		
Other serious event (specify) _		И		
6. Duration of event:	Hours _	Days		
7. Remarks:		1		
	/ *			
8. a. Name of physician who	provided RU	486 DAMY BU	Mons A	10
8. b. Physician's signature	X	1 . 1.		M. J. D.O
		Date 3/26//	~	
Send completed forms to:	State Me	edical Board of Ohio		Will Francis
	Legal De	epartment	1. Confe	JICAL BOARD
		oad St., 3 rd Floor		APR - 5 2012
	Columbi	ıs, OH 43215-6127		



Prescribed: 5/-/2011

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	6	2012
		Month	Day	Year
2. Name of medical practice				
Planned Parents	rood of	Northear	+ Ohio	
3. Address of medical practic	e or facility at w	hich RU-486 was	provided:	
25350 Rockende	. Rd Be	ed ford Hts	OH 4414	16
4. Date post RU-486 event be 3/20 l	12			
5. Event(s) (Please check all	that apply):			
Incomplete abortion	Adverse	e reaction to RU-486	Patient	thospitalized
Patient received a transfusion	Severe	bleeding		
Other serious event (specify)				
6. Duration of event:	Hours	Days		
7. Remarks:				
8. a. Name of physician who p	provided RIG-4	86 Saran K	Smith M	D
8. b. Physician's signature	(X)	10 8		M.D. / D.O
o. o. r riyololari o digilatare	Dat	3/2-	1/12	IVI.D. 7 D.O
Cond completed forms to				
Send completed forms to:		cal Board of Ohio	MED	GAL BOARD
	Legal Depa		- min I	UNIL DUARD
		d St., 3 rd Floor	Al	PR = 8 2012
	Columbus,	OH 43215-6127		
				/ N.