

Report #60



State Medical Board of Ohio Report of RU-486 Event

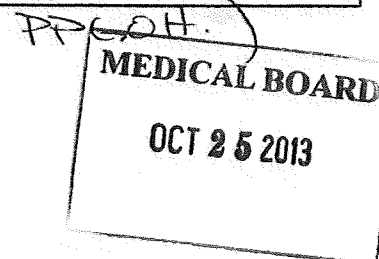
(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	09 Month	17 Day	2013 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 ROCKSIDE RD, BEDFORD HTS, OH 44146			
4. Date post RU-486 event began: 10-3-2013			
5. Event(s) (Please check all that apply):			
<input 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 checked="" type="checkbox"/> Other serious event (specify) FAILED MEDICATION ABORTION			
6. Duration of event: <1 Hours <input checked="" type="checkbox"/> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 DR DAVID BURKONS			
8. b. Physician's signature <u>Tina S. Krum</u> (KREBS, MD) M.D./D.O. Date 10/22/13 Medical Director			

Send completed forms to:

State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127



Report 56



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 8 13 2013
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:

Planned Parenthood of Greater Ohio Bedford Heights Surgical Center

3. Address of medical practice or facility at which RU-486 was provided:

25350 Rockside Rd. Bedford Hts. Ohio 44146

4. Date post RU-486 complication began:

9/6/13

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: 1 Hours _____ Days

7. Remarks:

Pt. delayed returning for medication abortion follow up vs.

8. a. Name of physician who provided RU-486

Dr. David Burkone

8. b. Physician's signature

[Signature]

M.D./D.O.

Date

9/24/12

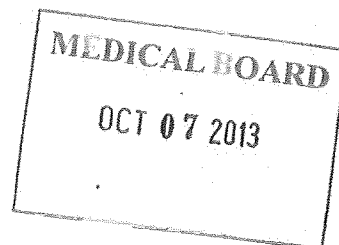
Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127




Report #55



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 Month	31 Day	2013 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 ROCKSIDE 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: 1 Hours 0 Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 DR DAVID BURKONS, MD			
8. b. Physician's signature  M.D./D.O.			
Date 9/4/13			

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MEDICAL BOARD

SEP 09 2013

Report 52



State Medical Board of Ohio Report of RU-486 Event

MEDICAL BOARD

JUL 22 2013

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>6</u> Month	<u>29</u> Day	<u>13</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>7/12/13</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Other serious event (specify) _____ <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Patient hospitalized			
6. Duration of event: <u>8</u> Hours <u>3</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>DR DAVID BURKENS</u>			
8. b. Physician's signature <u>[Signature]</u> Date <u>7/18/13</u> (M.D./D.O.)			

Send completed forms to:

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Columbus, OH 43215-6127

Report 46



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:	04	04	2013
	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 ROCKSIDE RD, BEDFORD HTS, OH 44146			
4. Date post RU-486 event began: 4/6/2013			
5. Event(s) (Please check all that apply): <input 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 checked="" type="checkbox"/> Other serious event (specify) ALLERGIC REACTION			
6. Duration of event: _____ Hours _____ Days UNKNOWN			
7. Remarks:			
8. a. Name of physician who provided RU-486 DR. DAVID BURKONS			
8. b. Physician's signature _____ M.D./D.O.			
Date 6/7/13			

Send completed forms to:

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MEDICAL BOARD

JUL 17 2013

Report 47



State Medical Board of Ohio Report of RU-486 Event

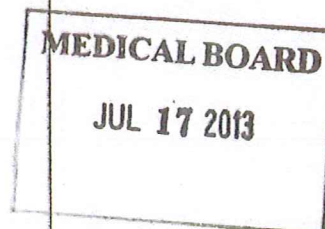
(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	4 Month	4 Day	2013 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 ROCKSIDE RD, BEDFORD HTS, OH 44146			
4. Date post RU-486 event began: 4/14/13			
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: <1 Hours 0 Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 DR DAVID BURROWS			
8. b. Physician's signature		M.D. / D.O.	
Date 6/7/13			

Send completed forms to:

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Report 48



State Medical Board of Ohio Report of RU-486 Event

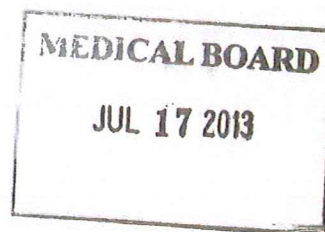
(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	4	2	2013
	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 ROCKSIDE RD, BEDFORD HTS, OH 44146			
4. Date post RU-486 event began: 4/18/13			
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: 0 Hours 7 Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 Dr. David Burkons			
8. b. Physician's signature M.D./D.O.			
Date 4/11/13			

Send completed forms to:

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Columbus, OH 43215-6127



Report 49



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

MEDICAL BOARD
JUL 17 2013

1. Date RU-486 was provided:	<u>4</u> Month	<u>9</u> Day	<u>13</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>4/26/13</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>21</u> Hours <u>0</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>DR SARAH LUNGEN</u>			
8. b. Physician's signature <u>[Signature]</u> Date <u>7/11/13</u> M.D./D.O.			

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MEDICAL BOARD
JUL 17 2013

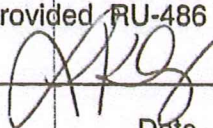
Report 50



State Medical Board of Ohio Report of RU-486 Event

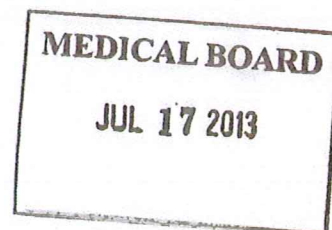
(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	06 Month	18 Day	2013 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 ROCKSIDE RD, BEDFORD HTS, OH 44146			
4. Date post RU-486 event began: 6/25/13			
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: 49 Hours 8 Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 DR SARAH LINGEN			
8. b. Physician's signature  M.D. / D.O. Date 7/2/13			

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Columbus, OH 43215-6127



Report 51



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>6</u> Month	<u>29</u> Day	<u>13</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>7/12/13</u>			
5. Event(s) (Please check all that apply):			
<input 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 checked="" type="checkbox"/> Other serious event (specify) <u>INFECTION ADEQUATELY TREATED WITH PO ANTIBIOTICS</u>			
6. Duration of event: <u>0</u> Hours <u>14</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>DR DAVID BURKONS, MD</u>			
8. b. Physician's signature <u>[Signature]</u>		<u>(M.D./D.O)</u>	
Date <u>7/18/13</u>			

Send completed forms to:

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Columbus, OH 43215-6127

MEDICAL BOARD

JUL 22 2013

Report 45



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:	3	6	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 ROCKSIDE RD, BEDFORD HTS, OH 44146			
4. Date post RU-486 event began: 3/21/13			
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: 41 Hours 0 Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 DR SARAH KENGEN			
8. b. Physician's signature		M.D. / D.O	
		Date 7/17/13	

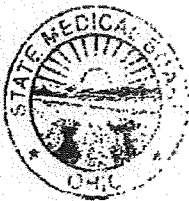
Send completed forms to:

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Columbus, OH 43215-6127

MEDICAL BOARD

JUL 17 2013

Report # 38

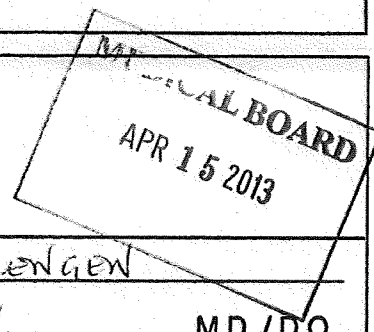


State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

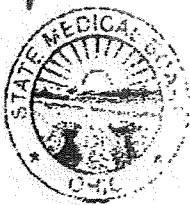
1. Date RU-486 was provided:	7	17	12
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: PLANNED PARENTHOOD OF GREATER OHIO			
3. Address of medical practice or facility at which RU-486 was provided: 25350 ROCKSIDE RD, BEDFORD HTS, OH 44146			
4. Date post RU-486 event 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: 21 Hours 0 Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 DR SARAH LUTGEN			
8. b. Physician's signature _____ M.D./D.O.			
Date 4/9/13			



Send completed forms to:

State Medical Board of Ohio
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Columbus, OH 43215-6127

report #4

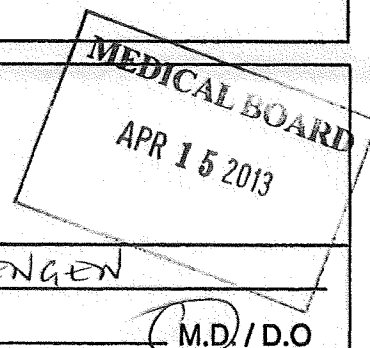


State Medical Board of Ohio Report of RU-486 Event

(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> Month	<u>26</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>3-14-13</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Other serious event (specify) _____ <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Patient hospitalized			
6. Duration of event: <u>< 1</u> Hours <u>6</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>DR SARAH LUNGEN</u>			
8. b. Physician's signature <u>[Signature]</u> Date <u>4/9/13</u> <u>(M.D./D.O.)</u>			



Send completed forms to:

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report # 40



State Medical Board of Ohio Report of RU-486 Event

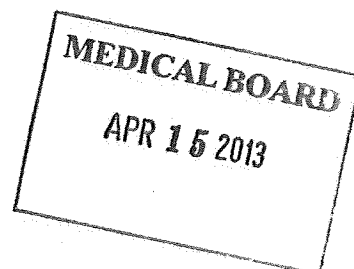
(Required pursuant to R.C. 2119.123)

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>< 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> Date <u>4/9/13</u> <u>(M.D. / D.O)</u>			

Send completed forms to:

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Report # 39

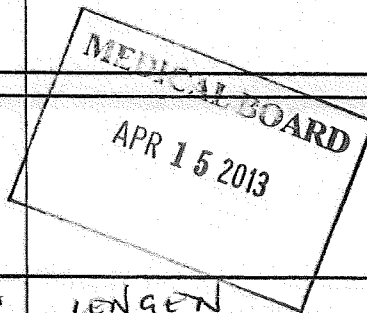


State Medical Board of Ohio Report of RU-486 Event

(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 ROULSIE RD, BEDFORD HTS, OH 44146			
4. Date post RU-486 event began:	3/8/13		
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 <u>DR SARAH LINGEN</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD./D.O.</u>			
Date <u>4/9/13</u>			



Send completed forms to:

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Columbus, OH 43215-6127

Report #29



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:	July	3	2012
	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 Rockside Rd Bedford Hts, OH 44146			
4. Date post RU-486 event began: 7/19/2012			
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: _____ Hours <u>1</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>David Burkons, MD</u>			
8. b. Physician's signature <u>[Signature]</u> M.D. / D.O. Date <u>1/18/13</u>			

Send completed forms to:

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Legal Department
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Columbus, OH 43215-6127

MEDICAL BOARD

JAN 24 2013

Report #30



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:	August	30	2012
	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 Rockside Rd, Bedford Hts, OH 44146			
4. Date post RU-486 event began: 9/15/2012			
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: _____ Hours <u>1</u> ^{hour} Days			
7. Remarks:			
8. a. Name of physician who provided RU-486: David Burkens, MD			
8. b. Physician's signature _____ M.D./D.O. Date <u>1/18/13</u>			

Send completed forms to:

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Legal Department
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Columbus, OH 43215-6127

MEDICAL BOARD

JAN 24 2013

Report #31



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>Sept</u> Month	<u>18</u> Day	<u>2012</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>10/2/12</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: _____ Hours <u>1</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Sarah Smith, MD</u>			
8. b. Physician's signature <u>[Signature]</u> M.D. / D.O. Date <u>1/15/13</u>			

Send completed forms to:

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MEDICAL BOARD

JAN 24 2013

Report # 33



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>10</u> Month	<u>17</u> Day	<u>2012</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</u> <u>BEDFORD HTS, OH 44146</u>			
4. Date post RU-486 event began: <u>11-8-12</u>			
5. Event(s) (Please check all that apply): <input 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 checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>1</u> Hours <u>0</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>DR DAVID GUNAKOWS, MD</u>			
8. b. Physician's signature _____ M.D. / D.O. Date <u>11/16/12</u>			

Send completed forms to:

State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD

JAN 24 2013

Report #34



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:	11	8	2012
	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 ROCKSIDE RD, BEDFORD HTS, OH 44146			
4. Date post RU-486 event began: 11/27/12			
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: <input checked="" type="checkbox"/> Hours 3 Days			
7. Remarks:			
8. a. Name of physician who provided RU-486: DR. DAVID BURKONS, MD			
8. b. Physician's signature: _____ (M.D./D.O.)			
Date: 11/8/12			

Send completed forms to:

State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD

JAN 24 2013

Report # 35



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>11</u> Month	<u>14</u> Day	<u>2012</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</u> <u>BEDFORD HTS, OH 44146</u>			
4. Date post RU-486 event began: <u>11/30/12</u>			
5. Event(s) (Please check all that apply): <input 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 checked="" type="checkbox"/> Other serious event (specify) <u>HEMATOMETRA TREATED WITH VASAPRIN</u>			
6. Duration of event: <u>21</u> Hours <u>8</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>DR DAVID BURKONS, MD</u>			
8. b. Physician's signature <u>[Signature]</u> <u>(M.D.) D.O.</u> Date <u>11/18/12</u>			

Send completed forms to:

State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD

JAN 24 2013

Report # 316



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>10</u> Month	<u>17</u> Day	<u>2012</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</u> <u>BEDFORD HTS, OH 44146</u>			
4. Date post RU-486 event began: <u>10/27/12</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Other serious event (specify) _____ <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Patient hospitalized			
6. Duration of event: <u>8</u> Hours <u>2</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>DR. DAVID BURKONS, M.D.</u>			
8. b. Physician's signature _____ M.D. / D.O. Date <u>1/18/13</u>			

Send completed forms to:

State Medical Board of Ohio,
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD

JAN 24 2013

Report #32



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>10</u> Month	<u>31</u> Day	<u>2012</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</u> <u>BEDFORD HTS, OH 44146</u>			
4. Date post RU-486 event began: <u>11/16/12</u>			
5. Event(s) (Please check all that apply): <input 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 checked="" type="checkbox"/> Other serious event (specify) <u>INFECTION</u>			
6. Duration of event: <u>8</u> Hours <u>14</u> Days			
7. Remarks: <u>TREATED WITH PO ANTIBIOTICS x 14 DAYS</u>			
8. a. Name of physician who provided RU-486 <u>DR DAVID BURKONS, M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> <u>11/16/12</u> <u>3</u> <u>(M.D.) D.O.</u> Date			

Send completed forms to:

State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD

JAN 24 2013