

(Required pursuant to R.C. 2119.123)

| 1. Date RU-486 was provided:                   |  |   |           |                |  |  |
|--|--|---|-----------|----------------|--|--|
| 1. Date NO-400 was provided.                   |  | - 66  | 07        | 2012           |  |  |
|  |  | Month                                       | Day       | Year           |  |  |
| 2. Name of medical practice or                 | facility at  | which RU-486 was p                          | orovided: |                |  |  |
| PPNEO  |  |   |           |                |  |  |
| 3. Address of medical practice of              |  | at which RU-486 was                         | provided: |                |  |  |
| 25350 ROULSIDE                                 |  |   |           |                |  |  |
| BEDFORD HEIGHTS                                | No. of Concession, Name of Street, or other Persons, Name of Street, or ot | 44146                                       |           |                |  |  |
| 4. Date post RU-486 event beg                  | an:  |   |           |                |  |  |
| 5. Event(s) (Please check all the              | at apply):   |   |           |                |  |  |
| Incomplete abortion                            | Adv  | erse reaction to RU-486                     | Patier    | t hospitalized |  |  |
| Patlent received a transfusion Severe bleeding |  |   |           |                |  |  |
| Other serious event (specify)                  | The Santa Constitution of the Santa Constitu |   |           | -              |  |  |
| 6. Duration of event:                          | _ Hours _  | IDays                                       |           |                |  |  |
| 7. Remarks:                                    |  |   |           |                |  |  |
|  |  |   |           |                |  |  |
|  |  |   | 1         |                |  |  |
| 8. a. Name of physician who pro                | ovided BL  | 1-486 DR/BA                                 | VID BUNK  | 13-            |  |  |
| 8. b. Physician's signature                    |  | Date (/27)                                  | 7/        | M.D. / D.O     |  |  |
| Send completed forms to:                       | State M  | edical Board of Ohio                        | J V       |                |  |  |
| cond completed forms to,                       |  |   |           |                |  |  |
|  |  | epartment<br>oad St., 3 <sup>rd</sup> Floor | NA.       | EDIGAL BOARD   |  |  |
|  |  |   | 1417      | LUIDAL BOARD   |  |  |
|  | Columbi  | us, OH 43215-6127                           |           | JUL 4 8 2012   |  |  |

Rept #5



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

(Required pursuant to R.C. 2119.123)

| Date RU-486 was provided:                  | Month                                 | 21<br>Day   |              |
|--|---------------------------------------|-------------|--------------|
| Name of medical practice or facility a     |                                       |             | Year         |
| Plumed Parenthood                          |                                       |             |              |
| 3. Address of medical practice or facility | 0                                     |             |              |
| 0  | 1 2 . [                               |             |              |
| 1960 Rollende R                            | a Beaford                             | l of 4470   | tle          |
| 4. Date post RU-486 event began:           |                                       |             |              |
| 5. Event(s) (Please clieck all that apply) | :                                     |             |              |
| Incomplete abortion Ad                     | dverse reaction to RU-486             | Patient     | hospitalized |
| Patient received a transfusion Se          | evere bleeding                        |             |              |
| Other serious event (specify)              |                                       |             |              |
| 6. Duration of event: Hours                | Days                                  |             |              |
| 7. Remarks: DSC for persist                | ent sae                               |             |              |
| 8. a. Name of physician who provided F     | 11-486 DAING BI                       | means N     | (D           |
|  | The same of                           | 1           | 115 15 6     |
| 8. b. Physician's signature                | Date                                  | neln        | M.D. / D.O   |
| Send completed forms to: State I           | Wedical Board of Ohio                 | 100         |              |
| Ĭ  | Department                            | ,           |              |
|  | Broad St., 3/6 Floqid                 | OC MAC 2102 |              |
|  |                                       |             |              |
| Colum                                      |                                       | U 20        |              |
| Colum                                      | bus, OH 43215-6127<br>017<br>08709 77 | OTOR BTATS  |              |

(Required pursuant to R.C. 2119.123)

| 1. Date RU-486 was provided:                                      |   | -5                     | 8         | 2012_           |
|---|---|------------------------|-----------|-----------------|
|   |   | Month                  | Day       | Year            |
| 2. Name of medical practice or                                    | facility at v                           | vhich RU-486 was pi    | rovided:  |                 |
| Planned Parenthon   | do                                      | Northeast              | Omo       |                 |
| 3. Address of medical practice o                                  | r facility at                           | which RU-486 was       | provided: |                 |
| 96350 Rochende  | Rd                                      | Beford                 | HIS OH    | + 44146         |
| 4. Date post RU-486 event bega                                    | n:                                      | U                      |           |                 |
| 5. Event(s) (Please check all tha                                 | t apply):                               |                        |           |                 |
| Incomplete abortion   | Adve                                    | rse reaction to RU-486 | Patie     | nt 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 pro                                   | vided RU                                | -486 Mund Bi           | ukons     | Mo              |
| 8. b. Physician's signature                                       |   |                        |           | M.D. / D.O      |
| L U   |   | ate                    |           |                 |
| Send completed forms to:  | State Me                                | dical Board of Ohio    |           | MEDION          |
| Legal Department  |   |                        |           | MEDICAL BOARD   |
| 30 E. Broad St., 3 <sup>rd</sup> Floor<br>Columbus, OH 43215-6127 |   |                        |           | JUN 28 2012     |
|   |   |                        | 2012      |                 |



(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                   | r facility at wh | nich RU-486 was p             | rovided:   |              |
| PPNEO  |                  |                               |            |              |
|  |                  |                               |            |              |
| 3. Address of medical practice 25350 ROULSIDE RD | or facility at v | which RU-486 was              | provided:  |              |
| BEDFORD HTS, OH 44                               | 146              |                               |            |              |
| 4. Date post RU-486 event beg                    | gan:             |                               |            |              |
| 5. Event(s) (Please check all the                | nat apply):      |                               |            |              |
| Incomplete abortion                              | Advers           | se reaction to RU-486         | Patient    | hospitalized |
| Patient received a transfusion                   | Severe           | e bleeding                    |            |              |
| Other serious event (specify)                    |                  |                               |            |              |
| 6. Duration of event:                            | Hours            | Ø _ Days                      |            |              |
| 7. Remarks;                                      |                  |                               |            |              |
|  |                  |                               |            |              |
| 8. a. Name of physician who p                    | rovided RU       | 186 DR. DAVID                 | BUPLKONS   |              |
| 8. b. Physician's signature                      | Øa<br>Øa         |                               | <i>?</i> / | M.D. / D.O   |
| Send completed forms to:                         | State Med        | ical Board of Ohio            | 1.45       |              |
|  | Legal Dep        |                               | MEDIC      | AL BOARD     |
|  | 30 E. Broa       | nd St., 3 <sup>rd</sup> Floor |            | 1 8 2012     |
|  | Columbus         | OH 43215-6127                 | -511       | 7 - COIC     |

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 facility    | at which RU-486 was p            | rovided:  |              |
| PANEO                                      |                                  |           |              |
|  |                                  |           |              |
| 3. Address of medical practice or facility | y at which RU-486 was            | provided: |              |
| 25350 NOCKSIDE RD                          |                                  |           |              |
| BEDFORD HEIGHTS, OH 441                    | 46                               |           |              |
| 4. Date post RU-486 event began:           |                                  |           |              |
| 6-6-12                                     |                                  |           |              |
| 5. Event(s) (Please check all that apply   | ):                               |           |              |
| Incomplete abortion A                      | Adverse reaction to RU-486       | Detiont   | boonitalised |
| Incomplete abortion                        | diverse reaction to no-400       | Patient   | nospitalizeo |
| Patient received a transfusion             | Severe bleeding                  |           |              |
|  | pereit blocaling                 |           |              |
|  |                                  |           |              |
| Other serious event (specify)              |                                  |           |              |
|  |                                  |           |              |
| 6. Duration of event: Hours                | s Days                           |           |              |
| 1  |                                  |           |              |
| 7. Remarks:                                |                                  | MEDIC     | CAL BOARD    |
| The transfer                               |                                  |           |              |
|  | / /                              | lui       | 1 1 3 2012   |
|  | $\mathcal{L}$                    |           |              |
| 8. a. Name of physician who previded       | AU-486 DAVID BU                  | inkens M  | δ            |
| ( )  |                                  |           |              |
| 8. b. Physician's signature                | 1/1/12                           |           | M.D. / D.O   |
|  | Date (// (// )                   | /         |              |
| Send completed forms to: State             | Medical Board of Ohio            |           |              |
| Legal                                      | Department                       |           |              |
| 30 E.                                      | Broad St., 3 <sup>rd</sup> Floor |           |              |
|  | nbus, OH 43215-6127              |           |              |



(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           | facility at which    | RU-486 was        | provided:   |                 |
| PPNED                                    |                      |                   |             |                 |
|  |                      |                   |             |                 |
| 3. Address of medical practice of        | or facility at which | ch RU-486 was     | s provided: |                 |
| 19550 ROCKSIDE                           | RD, BED)             | FORD, OH          | 44146       |                 |
| 4. Date post RU-486 event bega           | an:                  |                   |             |                 |
| 5. Event(s) (Please check all that       | at apply):           |                   |             |                 |
| Incomplete abortion                      | Adverse re           | eaction to RU-486 | Patie       | nt hospitalized |
| Patient received a transfusion           | Severe ble           | eding             |             |                 |
| Cther serious event (specify)            | Hematom etr          | ca-erro           | 1           |                 |
| 6. Duration of event:                    | _ Hours1.            | 3_ Days           |             |                 |
| 7. Remarks:                              |                      |                   |             |                 |
|  |                      |                   |             |                 |
|  | M                    | ,                 |             |                 |
| 8. a. Name of physician who pro          | wided RV-486         | DR. DA            | VID BURKO   | 13              |
| 8 h Physician's signature                | (VI)I                | 11                |             | M,D. / D.O      |
|  | Date                 | 5/4//             | 7           |                 |
| Send completed forms to:                 | State Medical        | Board of Ohio     | )           |                 |
|  | Legal Departr        | ,                 |             |                 |
| 01 -                                     | 30 E. Broad S        |                   |             |                 |
| 2012 MAY 29 PM 2: 15                     |                      | H 43215-6127      | ME          | DICAL BOARD     |
| STATE MEDICAL BOARD  Lescriped: 27-75011 |                      |                   |             | 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 which         | ch RU-486 was pr           | ovided:   |              |
| PPNEO                            | •                           |                            |           |              |
| 11117                            |                             |                            |           |              |
| 3. Address of medical practice   | or facility at wh           | nich RU-486 was I          | provided: |              |
| 19550 ROUKSIDE                   | RD.                         | BEDI                       |           |              |
| 4. Date post RU-486 event beg    | jan:<br><sup>2</sup> /17/12 |                            |           |              |
| 5. Event(s) (Please check all th | at apply):                  |                            |           |              |
| Incomplete abortion              | Adverse                     | reaction to RU-486         | Patient   | nospitalized |
| Patient received a transfusion   | Severe b                    | oleeding                   |           |              |
| Other serious event (specify)    |                             |                            |           |              |
| 6. Duration of event:            | Hours\$                     | Z Days                     |           |              |
| 7. Remarks:  It non  Langeleis   | er retu                     | and for f                  | =/a so    | dmtdnu       |
| 8. a. Name of physician who pr   | ovided RU-48                | 6 DR. SAVID                | Burkons   |              |
| 8. b. Physician's signature      | Date                        | 5/11/1                     | 7         | M.D./ D.O    |
| Send completed forms to:         | State Medic                 | al Board of Ohio           |           |              |
|                                  | Legal Depar                 | rtment                     |           |              |
| 2012 MA 85 YAM 2105              |                             | St., 3 <sup>rd</sup> Floor |           |              |
| OIHO do                          |                             | OH 43215-6127              | MED       | ICAL BOARD   |
| STATE MEDICAL BOARD              |                             |                            | ,         | MAY 29 2012  |

Prescribed: 5/--/2011

Report# 25



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

(Required pursuant to R.C. 2119.123)

| 1. Date RU-486 was provided:                   |  | 2                                       | 28           | 12/          |  |
|--|--|---|--------------|--------------|--|
|  |  | Month                                   | Day          | Year         |  |
| 2. Name of medical practice or                 | facility at which  | RU-486 was                              | provided:    |              |  |
|  |  |   |              |              |  |
| Planned Pareners                               | a of Nov   | theast                                  | Omo          |              |  |
| 3. Address of medical practice of              | r facility at whic   | h RU-486 w                              | as provided: |              |  |
| 25350 Rochende 1                               | 2d Be  | aford H                                 | ts 6H 441    | 46           |  |
| 4. Date post RU-486 event bega                 | ın:  | V                                       |              |              |  |
| 5. Event(s) (Please check all tha              | it apply):   |   |              |              |  |
| ✓ Incomplete abortion                          | Adverse rea  | action to RU-48                         | Patient      | hospitalized |  |
| Patient received a transfusion Severe bleeding |  |   |              |              |  |
| Other serious event (specify)                  |  |   |              |              |  |
| 6. Duration of event: Hours Days               |  |   |              |              |  |
| 7. Remarks:                                    | The state of the s | *************************************** |              |              |  |
|  |  | 1                                       |              |              |  |
|  |  |   |              |              |  |
|  |  |   |              |              |  |
| 8. a. Name of physician who pro                | vided RU-486   | David                                   | M Brmons     | MD           |  |
| 8. b. Physician's signature                    | TX // _  |   |              | MD /DO       |  |
| o. b. i riysician s signature                  |  |   | 4/19/12      | M.D. / D.O   |  |
|  | Date_  |   | 1/11/11/2    |              |  |
| Send completed forms to:                       | State Medical  | Board of Oh                             | io           |              |  |
|  | Legal Departm  | ent                                     |              | RARA         |  |
|  | 30 E. Broad S  | ., 3 <sup>rd</sup> Floor                | MEBIC        | SALBOARD     |  |
|  | Columbus, OF   | 43215-612                               | 7 W.         | 210S \$ 0 A  |  |



(Required pursuant to R.C. 2119.123)

| Date RU-486 was provided:                | 3                                   | 1         | 2012              |
|--|-------------------------------------|-----------|-------------------|
|  | Month                               | Day       | Year              |
| 2. Name of medical practice or faci      | lity at which RU-486 was prov       | vided:    |                   |
| Planned Parenthood                       | of Novmeast                         | Olio      |                   |
| 3. Address of medical practice or fa     |                                     |           |                   |
| 25350 Rockende Ro                        | d Bedford H                         | ts OH     | 44146             |
| 4. Date post RU-486 event began: 3/20/12 |                                     | 77        |                   |
| 5. Event(s) (Please check all that ap    | oply):                              |           |                   |
| Incomplete abortion                      | Adverse reaction to RU-486          | Patient I | nospitalized      |
| Patient received a transfusion           | Severe bleeding                     |           |                   |
| Other serious event (specify)            |                                     |           |                   |
| 6. Duration of event: He                 | ours Days                           |           |                   |
| 7. Remarks:                              | 1                                   |           |                   |
|  |                                     |           |                   |
|  | $\times$ /                          |           |                   |
| 8. a. Name of physician who provide      | ed RU486 Dand BUV                   | nons N    | D                 |
| 8. b. Physician's signature              | 14/1.1.                             |           | M.D. / D.O        |
|  | Date 3/26//                         |           |                   |
| Send completed forms to: St              | ate Medical Board of Ohio           | . 51      | in to I Partition |
| Le                                       | egal Department                     | ROLL      | IUAL BOARD        |
| 30                                       | E. Broad St., 3 <sup>rd</sup> Floor | A         | IPR - 5 2012      |
| Co                                       | olumbus, OH 43215-6127              |           |                   |