

State Medical Board of Ohio Report of RU-486 Event MEDICAL BOARD

(Required pursuant to R.C. 2919.123)

MAR 8 2016

		THE RESERVE THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER.		the state of the s
1. Date RU-486 was provided	l:	2	22	16
		Month	. Day	Year
2. Name of medical practice PLANNE	or facility at which	RU-486 was prov	rided:	
3. Address of medical practice 3255 E Ma				
4. Date post RU-486 complica	tion began:			
5. Event(s) (Please check all the Incomplete abortion		e reaction to RU-486	Patient hospitalized	
Patient received a transfusion	Severe bleeding			
Other serious event (specify)				
6. Duration of event:	Hours	Days		·
7. Remarks: failed 1	nto (non	viable 14	p) due to	
FDA regimen				
8. a. Name of physician who		Cay O Sate	herine Rom	
Send completed forms to:	State Med	ical Board of Ohio		
,	Legal Department	:		
	30 E. Broad St., 3 rd	^d Floor		2
*	Columbus, OH 43	215-6127		



(Required pursuant to R.C. 2919.123)

		THE RESERVE THE PARTY NAMED IN COLUMN 2 IS NOT THE OWNER.	
1. Date RU-486 was provided:	April	Day	2016 Year
2. Name of medical practice or facility at wi			
3. Address of medical practice or facility at v	which RU-486 was pro	ovided:	
3255 E Main St.	, columbus	OH 43:	213
4. Date post RU-486 complication began:	4/25/16		
5. Event(s) (Please check all that apply):	, ,		
Incomplete abortion Adv	verse reaction to RU-486	Patient hospitali	zed
Patient received a transfusion Severe bleed	ding		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks: failed Molication	on abothen,	continung	prognary
8. a. Name of physician who provided RU-49	BE ZOMA	WOS	
8. b. Physician's signature	J	Mo	2001
	Date	- 4	25/110
Send completed forms to: State M	edical Board of Ohio		
Legal Departme		M	EDICAL BOARD
30 E. Broad St.,			APR 26 2016
Columbus, OH	43215-6127		AT IN DU LUIU



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:	-	April	21 Day	2016 Year
2. Name of medical practice or fa	acility at which RL	J-486 was provide		Teal
3. Address of medical practice or	facility at which F	U-486 was provid	ed:	
3255 E. Mai				13213
4. Date post RU-486 complication	began:	122/16		
5. Event(s) (Please check all that	apply):	* * *		•
Incomplete abortion	Adverse rea	action to RU-486	_ Patient hospitalize	ed
Patient received a transfusion				
Other serious event (specify)				
6. Duration of event:	Hours	Days		
7. Remarks: D:C for bl	uding.			
8. a. Name of physician who prov	ided RII-486	Catherine	V =000	,
8. b. Physician's signature		A O	C)	
o. b. Physician's signature	Date -		4/27	(DO)
Send completed forms to:	State Medical	Board of Ohio		
Lega	l Department			
30 E	. Broad St., 3 rd Flo	or		
Colu	mbus, OH 43215	-6127	MED!	CAL BOARD

Prescribed: 5/--/2011, Rev. 12/13/12

MAY 2 2016



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	Thre	3	2016
	Month	Day	Year
2. Name of medical practice or facility at when the property of the property o			iáO
3. Address of medical practice or facility at w			
3255 E. Marin St	ambus	OH 4	343
4. Date post RU-486 complication began:	6/7/1	6	
5. Event(s) (Please check all that apply):			
Incomplete abortion Adv	erse reaction to RU-486	Patient hospita	alized
Patient received a transfusion Severe bleed	ling	M	EDICAL BOARD
Other serious event (specify)			JUN 13 2016
6. Duration of event: Hours	Days		
7. Remarks: meamplete expulsion severe fibrid when		due to	
8. a. Name of physician who provided RU-48 8. b. Physician's signature	Date	Cott	nerine Romanus D/DO 0/9/100
Send completed forms to: State M	edical Board of Ohio		
Legal Departme			
30 E. Broad St.,			
Columbus, OH	43215-6127		



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	Jure	10	2016
`	Month	Day	Year
2. Name of medical practice or facility at which		ejicaO	Center
3. Address of medical practice or facility at which	RU-486 was provide	d:	
3295 E. Main St.	countres	AL	13213
4. Date post RU-486 complication began:	6/15/16		
5. Event(s) (Please check all that apply):			
Incomplete abortion Adverse i	reaction to RU-486	Patient hospita	lized
Patient received a transfusion Severe bleeding			
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks: faled Medication a SIP D.C	lation		
8. a. Name of physician who provided RU-486			Rom Knos
8. b. Physician's signature Date	to 1		700_
Send completed forms to: State Medica	al Board of Ohio		
Legal Department 30 E. Broad St., 3 rd F	iloor	I	MEDICAL BOARD
Columbus OH 4321	5.6127		JUN 17 2016



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	August	16 Day	2016 Year
2. Name of medical practice or facility at wh PPGOH	ich RU-486 was provic	led:	
3. Address of medical practice or facility at w 3255 W Main S			ICAL BOARD AUG 29 2016
4. Date post RU-486 complication began:	8/24/2016		
5. Event(s) (Please check all that apply): Incomplete abortion Adve. Patient received a transfusion Severe bleed.	erse reaction to RU-486	Patient hospitaliz	red
X Other serious event (specify) Failed	medicul about	m	
6. Duration of event: Hours	Days	recognition of the state of the	
7. Remarks: Surgical completini of abov	twi	American state of the control of the	
8. a. Name of physician who provided RU-48	36 <u>C. Ro</u> v	nauos	
8. b. Physician's signature	Date 8/24/20		<u>/D.O</u>
Send completed forms to: State M Legal Departme 30 E. Broad St., Columbus, OH	3 rd Floor		
Prescribed: 5//2011, Rev. 12/13/12			



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:
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 complication began: 12 09 2014
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: MA Hours Days
7. Remarks: failed medical to likely result of FDA pwtocol.
8. a. Name of physician who provided RU-486 CARWANDS MV
8. b. Physician's signature Date 12 9 14
Sand completed forms to: State Medical Board of Ohio
Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3 rd Floor
Legal Department 30 E. Broad St., 3 rd Floor Columbus, OH 43215-6127
We VEC I

Prescribed: 5/--/2011, Rev. 12/13/12



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	Avaust	28,2014	
	Month	Day	Year
2. Name of medical practice or facility at which	RU-486 was provid	ded:	
3. Address of medical practice or facility at which	n RU-486 was prov	vided:	
COlumbus, OH 43213		The second secon	
4. Date post RU-486 complication began:			
September 12,2014			
5. Event(s) (Please check all that apply):			A APPENDING
Incomplete abortion Adverse	reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Severe bleeding			
Other serious event (specify)			
6. Duration of event: Na Hours	Days	the case and discount of	
7. Remarks: FD A protocol rosulted	in Inca	nplete p	wadure
8. a. Name of physician who provided RU-486	Cather	ine Karra	no8 MD.
8. b. Physician's signature Date	e 9/16/20	MD MD	/0.0
Send completed forms to: State Medic	cal Board of Ohio		
Legal Department			
30 E. Broad St., 3 rd	Floor	MED	ICAL BOARD
Columbus, OH 432	215-6127	S	EP 1 9 2014



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	Ortal	20.1 13 2017	
	Month	DEK 13, 2015	
			ear
2. Name of medical practice or fa	acility at which RU-486 wa	as provided:	
1101			
3. Address of medical practice or	facility at which RU-486 v	vas provided:	
355 East Main	St. Columbus,	04 43213	
4. Date post RU-486 complication 10 29 2015	began:		
5. Event(s) (Please check all that a	apply):	n *	
Incomplete abortion	7	RU-486 Patient hospitalized	
Patient received a transfusion	Severe bleeding		
Other serious event (specify)			
6. Duration of event:	Hours Days		
7. Remarks: Incomplete mac protocol.	dication aloution	following FDAa	pproved.
8. a. Name of physician who prov	ided RU-486	Catherine Romanas	
8. b. Physician's signature		MD DO	_
	Date ———	198/1	
Send completed forms to:	State Medical Board of	f Ohio	
Lega	l Department		
30 E	. Broad St., 3 rd Floor	MEDICAL BO	ARD
Colu	mbus, OH 43215-6127	NOV 2 201	



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State Medical Board of Ohio Report of RU-486 Event

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1. Date RU-486 was provide	d:	Lanuar	4	-	015
		Month	-	Day	Year
2. Name of medical practice	or facility at which	RU-486 was provid	led:		
		011.400			
3. Address of medical practic	ce or facility at which	1 RU-486 was prov	ided:		
3255 East N	Nain St., 1	Columbu.), Olt	432	13
4. Date post RU-486 complic		30/19	The state of the s		
5. Event(s) (Please check all	that apply):				
Incomplete abortion	Adverse	reaction to RU-486	Patie	nt hospitalized	ł
Patient received a transfusion	Severe bleeding		The state of the s		
Other serious event (specify)				1190	
6. Duration of event:	1 Hours	Days			
7. Remarks: Failed	Secondary	to FD	y Su	utoco!	,
8. a. Name of physician who	provided RIL-186	Cart	00000	Ryman	la 8
o. a. Maine of physician who	provided No-400		MIN	1-gillar)
8. b. Physician's signature				MOI	0.0
	Dat	te		2/3/15	
C- 1 1 1 1 C		10 1 601	1		
Send completed forms to:	State Medic	cal Board of Ohio			
	Legal Department		Name and April 2015		
	30 E. Broad St., 3 rd	Floor			
	Columbus, OH 432			MEDICA	LEOARD
				FEB	9 2015



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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

			į.		,
1. Date RU-486 was provided	•	Septemi	er 27	2016	1
		Month	Day	Year	
2. Name of medical practice of	or facility at which RI	U-486 was provid	led:		
3. Address of medical practice	or facility at which	RU-486 was prov	vided:		7.
3255 E. N	iainst C	olumas	of 4:	3213	
4. Date post RU-486 complica	tion began:	1/5/16			
5. Event(s) (Please check all the	nat apply):	t t			
Vincomplete abortion	Adverse re	eaction to RU-486	Patient hospitali	zed	
Patient received a transfusion	Severe bleeding		To the second se	MEDICAL BOARD	
Other serious event (specify)				OCT 1 7 2016	
6. Duration of event:	Hours	_ Days			
7. Remarks: IN COMPLE	e mtor	equired	Suction	produc	
8. a. Name of physician who	provided RU-486		Keder w	2) Certherine Ro	manu
8. b. Physician's signature	Date		5 10/19)100	
Send completed forms to:		al Board of Ohio			
	Legal Department				,
	30 E. Broad St., 3 rd F	loor			
	Columbus, OH 4321	15-6127			



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provide	ed:	17	28	2016
		Month	Day	Year
2. Name of medical practice Planked P			ed:. NAM (D	
3. Address of medical practi	ce or facility at w	hich RU-486 was prov	ided:	
32 55 E.	Main	st Colum	ous off	43213
4. Date post RU-486 compli		11/8/16		
5. Event(s) (Please check all	that apply):	¢		
Incomplete abortion	Adv	erse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion	n Severe bleed	ling		
Other serious event (specify)	Failed W	ledication Abo	rtion	
6. Duration of event:	Hours	Days		
7. Remarks:				
			Portugues and the second secon	
8. a. Name of physician who	nrovided RILA	86 Michel	le Islas	
	provided No 4	mlly	0	150
8. b. Physician's signature	•	Date / 11/18/	1	/ D.O
Send completed forms to:	State M	Nedical Board of Ohio		
completed forms to.	Legal Departm			
	30 E. Broad St.			
	Columbus, OH	•	MED	ICAL BOARD

Prescribed: 5//2011, Rev. 12/13/12			N	OV 21 2016



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	d: Novembe		er 3	2016
		Month	Day	Year
2. Name of medical practice or face Planned Parenth		J-486 was provi	ded:	
3. Address of medical practice or f 3255 East Main Columbus, OHI	street	•	vided:	
4. Date post RU-486 complication	began: 11/10/	16		
5. Event(s) (Please check all that a	pply):	additional in the second commence of the seco		
X Incomplete abortion	Adverse re	action to RU-486	Patient hospital	ized
Patient received a transfusion S	Severe bleeding		And the second s	
Other serious event (specify)				Notice of the Indiana and American
6. Duration of event:	Hours 19	_ Days		
7. Remarks:				
8. a. Name of physician who provi	idad BII-486	Cather	ine Roma	anos
	A A			2/00
8. b. Physician's signature —	Date		العوار	V-/
Send completed forms to:		l Board of Ohio		
·	l Department		1	
	. Broad St., 3 rd F	loor		
	ımbus, OH 4321		MED!	ICAL BOARD
			Al	OV 25 2016
Prescribed: 5//2011, Rev. 12/13/12			N	U & B & CAIA



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	November	<i>ର</i> ର	2010			
	Month	Day	Year			
2. Name of medical practice or facility at which Planned Parenthood		cal				
3. Address of medical practice or facility at whice 3255 East Main St Columbus, Onio 4321.	•					
4. Date post RU-486 complication began:						
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) Failed Abortion						
6. Duration of event: Hours Days						
7. Remarks: FDA Mudication abortion @ C on 12/13/14	Yw8d failed. I);C for a	engoing Ill			
8. a. Name of physician who provided RU-486 8. b. Physician's signature Date of physician who provided RU-486	Catherine te		anos 413/16			
Send completed forms to: State Medic	cal Board of Ohio		The state of the s			
Legal Department		1	Mrn			
30 E. Broad St., 3 rd	Floor	d	MEDICAL BOARD			
Columbus, OH 432	215-6127		DEC 1 6 2016			