MEDICAL BOARD

MAR 8 2016

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: 2 (Month) 22 (Day) 16 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 3255 E Main St. Columbus OH 43213

4. Date post RU-486 complication began:

5. Event(s) (Please check all that apply):

✓ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

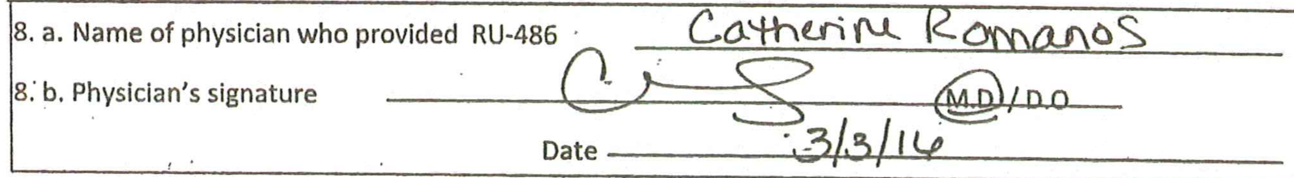
___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) ______________________

6. Duration of event: N/a Hours ________ Days

7. Remarks: failed MAB (non viable IUP) due to FDA regimen

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



8. b. Physician's signature ______________ M.D./D.O

Date 3/3/16

Send completed forms to: State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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: April (Month) 11 (Day) 2016 (Year)

2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East Surgical Center

3. Address of medical practice or facility at which RU-486 was provided: 3255 E Main St., Columbus OH 43213

4. Date post RU-486 complication began: 4/25/16

5. Event(s) (Please check all that apply):

X Incomplete abortion ___ Adverse 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 medication abortion, continuing pregnancy

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

8. b. Physician's signature [signature] M.D./D.O.

Date 4/25/16

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

MEDICAL BOARD
APR 26 2016

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

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: April (Month) 21 (Day) 2016 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus OH 43213

4. Date post RU-486 complication began: 4/22/16

5. Event(s) (Please check all that apply):

X Incomplete abortion em 4/27/16 ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ✓ Severe bleeding

___ Other serious event (specify) ____________________

6. Duration of event: ________ Hours ________ Days

7. Remarks: D:C for bleeding.

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

8. b. Physician's signature [signature] M.D./D.O

Date 4/27/16

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

MEDICAL BOARD

MAY 2 2016

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

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: June (Month) 3 (Day) 2016 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St Columbus OH 43213

4. Date post RU-486 complication began: 6/7/16

5. Event(s) (Please check all that apply):

✓ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

MEDICAL BOARD

JUN 13 2016

___ Other serious event (specify) ______________________

6. Duration of event: 24 Hours ________ Days

7. Remarks: incomplete expulsion of POC due to severe fibroid uterus.

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

8. b. Physician's signature [signature] M.D./D.O.

Date 6/9/16

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

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

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: June (Month) 10 (Day) 2016 (Year)

2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East Surgical Center

3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus OH 43213

4. Date post RU-486 complication began: 6/15/16

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: ______ Hours ______ Days

7. Remarks: failed medication abortion s/p D&C

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

8. b. Physician's signature [signature] MD/D.O

Date 6/15/16

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

MEDICAL BOARD
JUN 17 2016

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

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: August (Month) 16 (Day) 2016 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 W. Main St.
Columbus, OH 43213

MEDICAL BOARD
AUG 29 2016

4. Date post RU-486 complication began: 8/24/2016

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 medical abortion

6. Duration of event: 2 Hours ________ Days

7. Remarks:
Surgical completion of abortion

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

8. b. Physician's signature [signature] M.D./D.O.

Date 8/24/2016

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

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

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: 11/18/2014
Month Day Year

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

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: N/a Hours ______ Days

7. Remarks: failed medical Ab likely result of FDA protocol.

8. a. Name of physician who provided RU-486 Catherine Romanos MD

8. b. Physician's signature [signature] (M.D)/D.O

Date 12/9/14

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

MEDICAL BOARD
DEC 11 2014

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

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:	August 28, 2014 (Month / Day / Year)
2. Name of medical practice or facility at which RU-486 was provided: PPOH	
3. Address of medical practice or facility at which RU-486 was provided: 3255 East Main Street Columbus, OH 43213	
4. Date post RU-486 complication began: September 12, 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: N/a Hours ________ Days

7. Remarks:
FDA protocol resulted in incomplete procedure

8. a. Name of physician who provided RU-486 Catherine Romanos MD.

8. b. Physician's signature [signature] MD/D.O

Date 9/16/2014

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

MEDICAL BOARD
SEP 19 2014

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

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: October 13, 2015
   Month Day Year

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

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:
   10/28/2015

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: ______ Hours ______ Days

7. Remarks: incomplete medication abortion following FDA approved. protocol.

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

8. b. Physician's signature [signature] (M.D.) / D.O

   Date 10/28/15

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

MEDICAL BOARD

NOV 2 2015

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

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: January 13, 2015
   Month Day Year

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

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: 1/30/15

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: N/a Hours ________ Days

7. Remarks:
   failed secondary to FDA protocol

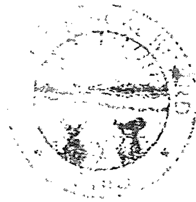
8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature [signature] M.D./D.O.

Date 2/3/15

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

MEDICAL BOARD
FEB 9 2015



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:	September (Month) 27 (Day) 2016 (Year)
2. Name of medical practice or facility at which RU-486 was provided:	Planned Parenthood
3. Address of medical practice or facility at which RU-486 was provided:	3255 E. Main St Columbus OH 43213
4. Date post RU-486 complication began:	10/5/16
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:	________ Hours ________ Days
7. Remarks:	incomplete MAB required suction procedure
8. a. Name of physician who provided RU-486	~~Lisa Keder~~ Catherine Romanos
8. b. Physician's signature	[signature] M.D./D.O. (M.D. circled)
Date	10/12/16

MEDICAL BOARD

OCT 17 2016

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

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

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: 11 (Month) 28 (Day) 2016 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St Columbus OH 43213

4. Date post RU-486 complication began: 11/8/16

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) Failed Medication Abortion

6. Duration of event: ________ Hours 11 Days

7. Remarks:

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

8. b. Physician's signature [signature] M.D./D.O

Date 11/18/16

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

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

MEDICAL BOARD

NOV 21 2016

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: November (Month) 3 (Day) 2016 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 East Main Street
Columbus, OHIO 43213

4. Date post RU-486 complication began: 11/10/16

5. Event(s) (Please check all that apply):

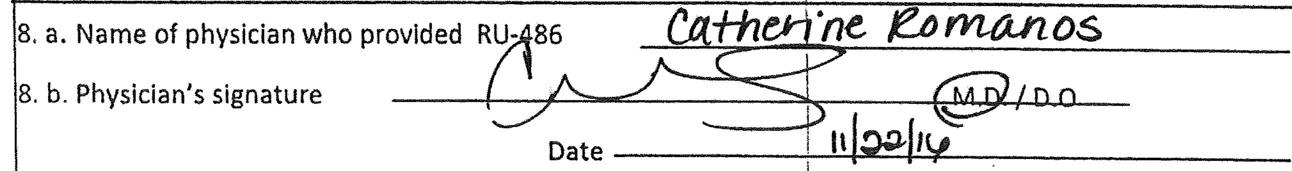
X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) ___

6. Duration of event: ___ Hours 19 Days

7. Remarks:



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

8. b. Physician's signature [signature] M.D./D.O.

Date 11/22/16

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

MEDICAL BOARD
NOV 25 2016

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

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: November (Month) 22 (Day) 2016 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 East Main St
Columbus, Ohio 43213

4. Date post RU-486 complication began:
12/6/16

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 ~~14~~ 21 Days

7. Remarks:
FDA medication abortion @ 9w3d failed. D&C for ongoing IUP on 12/13/16.

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

8. b. Physician's signature [signature] (M.D.)/D.O.

Date 12/13/16

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

MEDICAL BOARD
DEC 16 2016

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