

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.			

Send completed forms to:

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

MEDICAL BOARD

JUL 17 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:	5	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 LUNGEN			
8. b. Physician's signature		M.D. / D.O.	
		Date 7/11/13	

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MEDICAL BOARD

JUL 17 2013

Report 50



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

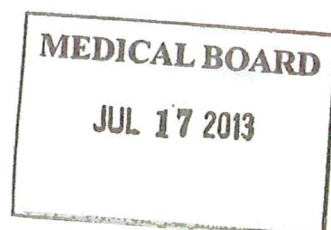
(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	06	18	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:	4/25/13		
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 08 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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Report # 38

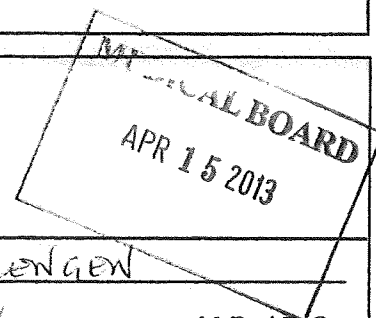


# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	7 Month	17 Day	12 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 LUNGEN			
8. b. Physician's signature _____ M.D. / D.O.			
Date 4/9/13			



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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"/> 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>&lt; 1</u> Hours <u>6</u> Days			
7. Remarks: <div style="text-align: right;"></div>			
8. a. Name of physician who provided RU-486 <u>DR SARAH LUNGEN</u>			
8. b. Physician's signature <u>[Signature]</u> <u>4/9/13</u> <u>M.D./D.O.</u> Date			

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report # 40



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

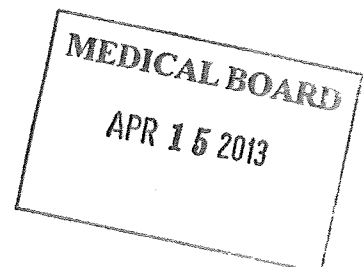
(Required pursuant to R.C. 2119.123)

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>&lt; 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> <u>4/9/13</u> M.D. / D.O.			

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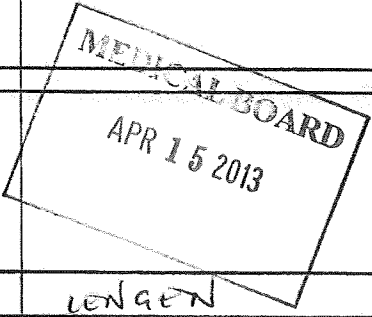
report # 39



# 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:	<u>2</u> Month	<u>19</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 ROULSIE RD, BEDFORD HTS, OH 44146</u>			
4. Date post RU-486 event began: <u>3/8/13</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>8</u> Hours <u>1</u> Days			
7. Remarks:			
<div style="text-align: right;">  </div>			
8. a. Name of physician who provided RU-486 <u>DR JANNA LONGEN</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD./D.O.</u>			
Date <u>4/9/13</u>			

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