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:	Sept (Month)	18 (Day)	2012 (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:
10/2/12

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 1 Days

7. Remarks:

8. a. Name of physician who provided RU-486 Sarah Smith, MD

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

Date 1/15/13

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

Prescribed: 5/--/2011

Report #27

State Medical Board of Ohio

Report of RU-486 Event

MEDICAL BOARD
SEP 10 2012

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: June (Month) 12 (Day) 2012 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25360 Rockside Rd
Bedford Hts, OH

4. Date post RU-486 event began:
6/29/12

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:

8. a. Name of physician who provided RU-486 Sarah K Smith MD

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

Date 9/4/12

Send completed forms to:

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

Prescribed: 5/--/2011

Rpt #16

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	10	2011
	Month	Day	Year

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

PPNEO

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

19550 ROCKSIDE RD, BEDFORD, OH 44146

4. Date post RU-486 event began: 12/3/11

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) HEMATOMETRA

6. Duration of event: 1 Hours Ø Days

7. Remarks:

8. a. Name of physician who provided RU-486 DR. SARAH SMITH

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

Date 6/12/12

Send completed forms to:

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

MEDICAL BOARD
JUN 19 2012

Prescribed: 5/--/2011

Rpt #11

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: 10 (Month) 4 (Day) 2011 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
19550 ROCKSIDE RD, BEDFORD, OH 44146

4. Date post RU-486 event began:
10/19/11

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) HEMATOMETRA

6. Duration of event: 1 Hours Ø Days

7. Remarks:

8. a. Name of physician who provided RU-486 DR. SARAH SMITH

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

Date 5/22/12

Send completed forms to:

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

2012 MAY 29 PM 2:15
STATE MEDICAL BOARD OF OHIO

MEDICAL BOARD
MAY 29 2012

Prescribed: 5/--/2011

Rept # 10

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	01	2011
	Month	Day	Year

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

PPNEO

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

19550 Rockside Rd, Bedford, OH 44146

4. Date post RU-486 event began:

11/17/11

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:

8. a. Name of physician who provided RU-486 Dr. Sarah Smith

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

Date 5/22/12

Send completed forms to:

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

2012 MAY 29 PM 2:15
STATE MEDICAL BOARD OF OHIO

MEDICAL BOARD
MAY 29 2012

Prescribed: 5/--/2011

Report #26

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 (Month) 13 (Day) 2012 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood of Northeast 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:
4/5/12

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:

8. a. Name of physician who provided RU-486 Sarah K Smith MD

8. b. Physician's signature _____ M.D. / D.O
Date 5/1/12

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

MEDICAL BOARD
MAY 04 2012

Prescribed: 5/--/2011

Report #24

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 (Month) 27 (Day) 2012 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood of Northeast 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: 4/14/12

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:

8. a. Name of physician who provided RU-486 Sarah K Smith MD

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

Date 4/24/12

Send completed forms to:

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

MEDICAL BOARD
MAY 04 2012

Prescribed: 5/--/2011

Report # 22

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 (Month) 6 (Day) 2012 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood of Northeast 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:
3/20/12

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:

8. a. Name of physician who provided RU-486 Sarah K Smith MD

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

Date 3/27/12

Send completed forms to:

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

MEDICAL BOARD
APR - 2 2012

Prescribed: 5/--/2011

✓ Rept # 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: 12 (Month) 9 (Day) 11 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
19550 Rockside Rd Bedford OH 44146

4. Date post RU-486 event began:
12/22/11

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: 2 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Sarah K Smith, MD

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

Date 1/24/12

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

Prescribed: 5/--/2011