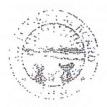


(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	12	2	16
	Month	Day	Year
2. Name of medical practice or facility Planned Parenthood	7	ded:	
3. Address of medical practice or facility 2314 Auburn Augusta			
4. Date post RU-486 complication bega	n:		
5. Event(s) (Please check all that apply)	:		
Incomplete abortion	Adverse reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe	bleeding		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks: completed S	urfically		
3. a. Name of physician who provided 1	RU-486	D. Kal	54
3. b. Physician's signature	Male Date	(M.D.)	D.O.
end completed forms to: Sta	te Medical Board of Ohio		
Legal Depa 30 E. Broa	artment d St., 3 <sup>rd</sup> Floor	MED	ICAL BOARD
	OH 43215-6127	D	EC 2 7 2016

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



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	//	22	16
	Month	Day	Year
2. Name of medical practice or facility at w Planned Parenthood	hich RU-486 was provid	led:	
3. Address of medical practice or facility at 2314 Auburn Au.			
4. Date post RU-486 complication began:	12/3/16.		
5. Event(s) (Please check all that apply):	verse reaction to RU-486	Patient hospitalize	d
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks: Du ( done without	incident.		
8. a. Name of physician who provided RU-4.	Date D	12/11 6 R.	
Send completed forms to: State M	ledical Board of Ohio		The second secon

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL DOALD

DEC 1 2 2016



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	_10	25	16
	Month	Day	Year
2. Name of medical practice or facility Planned Parenthoo	/	vided:	
3. Address of medical practice or faci	lity at which RU-486 was pro	ovided:	
2314 Auburn Au	e. ana, of	45219	
4. Date post RU-486 complication be	gan:		
5. Event(s) (Please check all that appl	y):		
Incomplete abortion	Adverse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Seve	re bleeding		
Other serious event (specify)	iled medication	Abstion	
6. Duration of event: 3 Hou	rs Days		
7. Remarks: completed supic	iely without is	Su	
8. a. Name of physician who provided	RU-486	Dr. Pickle	
8. b. Physician's signature	Date Date	12/p/110	90
Send completed forms to: S	tate Medical Board of Ohio		
	partment		
30 E. Bro	ad St., 3 <sup>rd</sup> Floor		

Columbus, OH 43215-6127

MEDICAL BOARD

DEC 12 2016



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	10	4	14
	Month	Day	Year
2. Name of medical practice or facility at whice Planned Parenthose	Λ	ded:	
3. Address of medical practice or facility at white 2314 Auburn Aut,			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Incomplete abortion Advers	se reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe bleeding	3		
Other serious event (specify) Failed	medica	tia Mor	+;0
6. Duration of event: Hours	Days when	pt return	of for surject
7. Remarks:			
8. a. Name of physician who provided RU-486 8. b. Physician's signature	0) W Clc 1216	e Pickle	do_
	lical Board of Ohio		

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

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

DEC 12 2016



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	10	4	16
	Month	Day	Year
2. Name of medical practice or facility at which I Planned Parenthood			io
3. Address of medical practice or facility at which 2314 Auburn Aw		ided:	
1. Date post RU-486 complication began:			
10/16/16			
5. Event(s) (Please check all that apply):			
Incomplete abortionAdverse i	reaction to RU-486	Patient hospitalize	ed
		-	
Patient received a transfusion Severe bleeding			
Patient received a transfusion Severe bleeding			
Patient received a transfusion Severe bleeding Other serious event (specify)	Days		
Patient received a transfusion Severe bleeding Other serious event (specify) 6. Duration of event: 3 Hours	_ Days without		

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

NOV 0 7 2016



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	8	11	16
	Month	Day	Year
2. Name of medical practice or facility at which Planned Parenthood S.			
3. Address of medical practice or facility at white 2314 Auburn Aw.			45219
4. Date post RU-486 complication began: 9/1///			
5. Event(s) (Please check all that apply):			
Incomplete abortion Adverse	e reaction to RU-486	Patient hospita	alized
Patient received a transfusion Severe bleeding			
LOther serious event (specify) Failed Ab	oction co,	meleted	Sergically.
6. Duration of event: Hours	Days		
7. Remarks:			
	~	1/ 1	
8. a. Name of physician who provided RU-486	O. Dr.	Kaly.	
8. b. Physician's signature  Da	te	10/4/16	D/DO
Send completed forms to: State Medi	ical Board of Ohio		
Legal Department 30 E. Broad St., 3 <sup>rd</sup>			MEDICAL BOA

Columbus, OH 43215-6127

OCT 11 2016



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	9	9	16
	Month	Day	Year
2. Name of medical practice or facility at w Planned Parenthood			
3. Address of medical practice or facility at	which RU-486 was pro	vided:	
2314 Auburn A	ve, ancie	nati, o	H 45219
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Incomplete abortionAd	verse reaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion Severe blee	ding		
Other serious event (specify)			
6. Duration of event: Hours	Days (pl	us time in	ER for transfu
7. Remarks:			
١,			
8. a. Name of physician who provided RU-4	0	Dr. Kalsy	
8. b. Physician's signature	Date 10/	14/16 M.D.	/0.0
Send completed forms to: State N	Medical Board of Ohio		
Legal Departm			
30 E. Broad St.	., 3 <sup>rd</sup> Floor		MEDICAL BOAR

OCT 11 2016

Columbus, OH 43215-6127



MEDICAL BOARD

(Required pursuant to R.C. 2919.123)

SEP 23 2016

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:		8	16		16
		Month	Day	,	/ear
2. Name of medical practice or facility	at which RU-4	86 was prov	ided:		
Planned Parenthood	Sout	houst	Ohio s	legion	
3. Address of medical practice or facility	at which RU-	486 was pro	vided:		
2314 Auburn +	Aur.	Cincin	rati, o	# 4	5219
4. Date post RU-486 complication began	n:				
5. Event(s) (Please check all that apply):					
/Incomplete abortion	_ Adverse reacti	on to RU-486	Patient hospit	alized	
Patient received a transfusion Severe	bleeding				
Other serious event (specify)					
6. Duration of event: Hours	D:	в <b>у</b> s			
7. Remarks: D+C dane with	out;	Su.			
8. a. Name of physician who provided F	RU-486	a Sai	ah Pid	th.	
8. b. Physician's signature	Date	1/ 91	120/16 M	D./D.O.	
Send completed forms to: Sta	te Medical Bo	oard of Ohio			
Legal Depa	artment				
30 E. Broad	d St., 3rd Floor	•			

Columbus, OH 43215-6127



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	06	25	16
	Month	Day	Year
2. Name of medical practice or facility at			6600
y warren journ in a			<u> </u>
3. Address of medical practice or facility a 2314 Auburn Augusta Ghuhnati off 45		vided:	
4. Date post RU-486 complication began: $\mathcal{A}/9/14$			
5. Event(s) (Please check all that apply):			
가 보면 수없는 경험에 보면 보면 하는 것이 되었다. 			MEDICAL BOA
Incomplete abortion	Adverse reaction to RU-486	Patient hospitali	
			AUG 12 2016
Patient received a transfusion Severe bl	leeding		
Other serious event (specify)	riled Ab, c	ompleted	will Sarpry
6. Duration of event: Hours _	Days		
7. Remarks:		ng Lagranger (Ang <del>Lagrange and Ang Lagrange and Ang Lagr</del>	
			* 1
· · · · · · · · · · · · · · · · · · ·			-
8. a. Name of physician who provided RL	J-486/3 Shar	on hine	
o to physician to discuss the second			
8. b. Physician's signature	Data 9/	2/16	7 U.O
Send completed forms to: State	Date		
/ Legal Depar			
30 E. Broad	St., 3 <sup>rd</sup> Floor		
	OH 43215-6127		



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provide	e <b>d:</b>	Month	$\widetilde{\mathcal{U}}_{\scriptscriptstyle D}$	5 1016 Pear Year	
2. Name of medical practic	e or facility at wh	ich RU-486 was pr	ovided:		
3. Address of medical practi	ice or facility at w	hich RU-486 was į	orovided:		
3255 East Ma	in St. i	Clumbu	10H 4	3213	
4. Date post RU-486 compli					
5. Event(s) (Please check all	that apply):				
∕∕o Incomplete abortion	Adve	rse reaction to RU-48	36Patient	hospitalized	
Patient received a transfusion Other serious event (specify)		ng			
6. Duration of event:	る_Hours	Days			
7. Remarks: Failed medu	ealalns him cu	uphted swgi	rálly		
8. a. Name of physician who	provided RU-48	6 Rom	anos		
8. b. Physician's signature		Date 7/19	Trong	M.D. / D.O	
Send completed forms to:	State Me	edical Board of Oh	io		
•	Legal Departme			MEDICAL BOARD	
	30 E. Broad St.,				
and the state of	Columbus, OH 4	13215-6127		JUL 18 2016	



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

<ol> <li>Date RU-486 was provided:</li> </ol>	3	5 2		16	
	Mor	nth Day		Year	
2. Name of medical practice or fac	cility at which RU-486	was provided:			
Planned Parent	hood South	just Ohio	Regi	on	
3. Address of medical practice or f	acility at which RU-48	6 was provided:			
2314 Auburn	Ave., C	inchnat;	OH	45219	
4. Date post RU-486 complication 3/23/16					
5. Event(s) (Please check all that a	pply):				
Incomplete abortion		to DI 1 495 Designs to	a an in a line al	MEDICA	1,14
incomplete abortion	Adverse reaction i	to RU-486 Patient h	ospitalized		
Patient received a transfusion	Severe bleeding			APR 12 2	016
Other serious event (specify)					
Other serious event (specify)					
6. Duration of event:					
6. Duration of event:	Hours2_ Days				
6. Duration of event:	Hours2_ Days				
6. Duration of event:  7. Remarks:  Doing well \$\bar{p}\$	Hours 2 Days				
6. Duration of event:	Hours 2 Days	Man	The state of the s	~/	
6. Duration of event:  7. Remarks:  Doing well \$\bar{p}\$	Hours 2 Days	Man	60/0		
6. Duration of event:  7. Remarks:	Hours Days	, Marson 4/2/14	The state of the s		

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