(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provi	ded:	Mosch	1	20.10
3/		Month	Day	Year
2. Name of medical practi				
[Northeast	Chic Wi	men'c	Center	
3. Address of medical prac	tice or facility at which R	U-486 was provid	ded:	
1211154	ate In			
4. Date post RU 486 comp	lication began:			
5. Event(s) (Please check a	Il that apply):			
Incomplete abortion	Adverse read	tion to RU-486	Patient hospitalized	
Patient received a transfusion	on Severe bleeding			
Other serious event (specify	)			
6. Duration of event:	3Hours1	Days		
7. Remarks: ft h	ad 0+e	witho	uteomp	1104/1015
8. a. Name of physician who	o provided RU-486	J. M. W.	Ason A	1.1
8. b. Physician's signature	Date -	5/18/	MD/DC	<u> </u>
Send completed forms to:	State Medical B	oard of Ohio		
<b>6%</b>	· Legal Department			
	30 E. Broad St., 3 <sup>rd</sup> Floo	r /		
	Columbus, OH 43215-6		MEDICAL BO	ARÓ
Described to the description			MAY \$ 6 30'	Ţ7

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 provi	ded:	March	27	2010
3/22/17		Month	Day	Year
2. Name of medical practi	ce or facility at which RU	l-486 was provided:		
North	east Chic	Mamer's	Port	general de la company de l De la company de la company
				<i></i>
3. Address of medical prac 21249 S		U-486 was provided		
To water	Tate RA	Clh I.	בר העונו	
4. Date post RU-486 comp	lication began:	Chia .	77623	
4/28/1	**************************************			
5. Event(s) (Please check a	Il that apply):			
Incomplete abortion	Adverse rea	ction to RU-486 Pa	atient hospitalized	
Patient received a transfusion	on Severe bleeding			
	Jevere bleeding			
Other serious event (specify	A)			
other serious event (specify				<del></del>
6. Duration of event:		Days		
7.0				
7. Remarks:	1ad Dac	withou	I Con	noluution
•		, ,		
8. a. Name of physician wh	o provided RU-486	L. ann 1	unnal	1/4
8. b. Physician's signature	•		W 11124 /	1
o. b. i frysician s signature		Xhol	/M.D./D	5/14/17
	Date -	the Item	July Cop Mi	7271
Send completed forms to:	State Medical E	Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 <sup>rd</sup> Floo	or	A MA SOMEWAY COME A COME	The state of the s
	Columbus, OH 43215-	6127	MFD100	
			yίΔΫ́	र शाह

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 provide	<b>d:</b>			13	2017
2. Name of medical practice  Northeast OHio			provided:	Day	Year
3. Address of medical practic					
4. Date post RU-486 complica					
5. Event(s) (Please check all t	nat apply):				
Incomplete abortion	Adverse	e reaction to RU-	486 Pati	ent hospitalize	<b>d</b>
Patient received a transfusion Other serious event (specify)	Severe bleeding				
6. Duration of event:	Hours	Days			
7. Remarks: Pt. had ( Neavy bloeding a but pregnancy wa	t) ptu po nd on ui us resolved	ost Medi Itma Sound 1. pt ha	cation there	Aborgtion was re DEC or	n. She had maining tussue 8/22/17
8. a. Name of physician who p 8. b. Physician's signature	rovided RU-486,	Q/1	LlynD 117	Junnully MD/	D.O
Send completed forms to:	State Medi	cal Board of O	hio		
· L	egal Department				
3	0 E. Broad St., 3 <sup>rd</sup>	Floor			
C	Columbus, OH 432	215-6127		MEDICA	U BOARD

SEP 1 5 2017

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provid	ed:	1	10	2017
		Month	Day	Year
2. Name of medical practic	e or facility at which	RU-486 was provid	led:	
Northeast 0				
3. Address of medical pract	ce or facility at whic	h RU-486 was prov	ided:	
2127 Sta	te Rd (	Mahoga &	alls OHio	44223
4. Date post RU-486 compli	cation 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:				
7. Remarks: DOS+ W	ed as pat	rent had	A Samara	. dectations
7. Remarks: POST W SOIC W/NO Fetal	poie developed	OR Remaining	· Patient h	ad Déc
01 7/27/17 to	Complete her	2 process.	,	, –
8. a. Name of physician who			ip Burkons	
8. b. Physician's signature	Date	it of 10	(M)/D	0
Send completed forms to:	State Medica	al Board of Ohio		
<b>**</b> .	Legal Department			
	30 E. Broad St., 3 <sup>rd</sup> F	ilonr		
	Columbus, OH 4321			,
		rD-017/	MEDICAL BO	ARD

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

SEP 1 5 2017

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	Octob	, (1)	21	2017
	Month		Day /	Year
2. Name of medical practice or facility $N_{cr} + N_{eas} + C$	y at which RU-486 was p 7/h 10 Woma	provided:	Her	164
3. Address of medical practice or facili				
Ougstyn Falls	Chio YH	723		
4. Date post RU-486 complication beg	an:	<u> </u>		
1,74,7				
5. Event(s) (Please check all that apply	·):			
Into Applete abortion	Adverse reaction to RU-4	.86 Patient	hospitalized	
Patient received a transfusion Sever	e bleeding	,		
Other serious event (specify)				<u>.</u>
6. Duration of event: Hour	s Days			
7. Remarks: a oustin of . E without difficult	) war pref.	medon	11/14/19	
8. a. Name of physician who provided	RU-486 Jenni	For W	atson	
8. b. Physician's signature	Valson			
	Date	17	M.D./D.O	
Send completed forms to: Sta	ate Medical Board of Oh	io		
Legal Depa	artment			
30 E. Broa	d St., 3 <sup>rd</sup> Floor	,	MEDICAL E	30AR!
Columbus	OH 43215-6127	•	NOV 27	•

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

5