

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was prov	ided:	2	25	17
	M	onth	Day	Year
2. Name of medical pract	ice or facility at which RU-481 enthool	6 was provided	d:	
3. Address of medical prac	tice or facility at which RU-4	86 was provide	ed:	
2314 Aubur.	n Au. ana,	OH 4	15219	
4. Date post RU-486 comp	lication began: 3 11 H			
5. Event(s) (Please check a				
Incomplete abortion	Adverse reaction	to RU-486	Patient hospitalized	
Patient received a transfusi	onSevere bleeding			
₩ Other serious event (specifi) Foiled Mb.	ortion.		
6. Duration of event:	2 Hours Days			
7. Remarks: Campleted	Surgically with	hout in	ci dent.	
8. a. Name of physician wh	o provided RU-48ß	,),	Kalin	
8. b. Physician's signature	- 1 hal	-73	(MD)/DO	
	Date ——	3/11/1		
Send completed forms to:	State Medical Board	d of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd Floor		EDICAL BOAR	*)
	Columbus, OH 43215-6127	7	MAR 84 2017	



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provi	ded:	2	28	17
		Month	Day	Year
2. Name of medical pract	//	U-486 was provi	ded:	
3. Address of medical prac	tice or facility at which	RU-486 was pro	vided:	
2314 Aubur.	n Au. an	a, oH	45219	
4. Date post RU-486 comp	lication began: 3 114	la		
5. Event(s) (Please check a		- i · i · i ·		
✓ Incomplete abortion	Adverse re	action to RU-486	Patient hospitaliz	ed
Patient received a transfusi	on Severe bleeding			
Other serious event (specify	<i>(</i>)			
6. Duration of event:	<u>2</u> Hours	Days		
7. Remarks: D + C per +01	med without	incident	,	
8. a. Name of physician wh	o provided RU-486	1	r. Pickle	
8. b. Physician's signature	Date -	3/21/0	MO	20.0
Send completed forms to:	State Medical	Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd Flo	or	NACT	DICAL BOARD
	Columbus, OH 43215			
	,			MAR 3 1 2017



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	11 17
Month	Day 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 provide	d:
2314 Auburn Aus. ana, of 4	(5219
4. Date post RU-486 complication began:	
5. Event(s) (Please check all that apply):	
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: Dy (done without incindent	
8. a. Name of physician who provided RU-486	De Gint
8. b. Physician's signature	Molpo
Date4/5//	7
Send completed forms to: State Medical Board of Ohio	
Legal Department	
30 E. Broad St., 3 rd Floor	MEDICAL BOARD
Columbus, OH 43215-6127	APR 14 2017

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

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Cincinnati

Medical Board of Ohio t of RU-486 Event

Required pursuant to R.C. 2919.123)

completed by the physician who provided RU-486

		and by the physician with	י די	
		_3	29	17
		Month	Day	Year
1 0: 4 0		which RU-486 was prov	vided:	
Planned Par	unthood	-		
3. Address of medical pra	ctice or facility	at which RU-486 was pro	ovided:	
2314 Aubur	n Au.	ana, of	45219	
4. Date post RU-486 com	plication began:			
5. Event(s) (Please check	all that apply):			
Incomplete abortion		Adverse reaction to RU-486	Patient hospitalized	
Patient received a transfus	ion Severe bl	eeding		
Other serious event (specif	ÿ)			MEDICAL BO
6. Duration of event:	2 Hours _	Days		MAY 1 2 20
7. Remarks:				
8. a. Name of physician wh	o provided RU-	486 ,	Dr. Killen	
8. b. Physician's signature	_	111alm Date 5/9/17	MD/0	.0
Send completed forms to:	State	Medical Board of Ohio		
	Legal Departr	ment		
	30 E. Broad St	t., 3 rd Floor		
	Columbus, Ol	H 43215-6127		



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was prov	vided:	4		17
		Month	Day	Year
2. Name of medical prac	tice or facility at which RU-2	86 was prov	rided:	1001
3. Address of medical pra	ctice or facility at which RU	-486 was pro	ovided:	
2314 Aubur	n Au. lina	, 0+1	45219	
4. Date post RU-486 com	plication began: レ/ 27 /17			
5. Event(s) (Please check				
✓ Incomplete abortion	Adverse reaction	on to RU-486	Patient hospitali	zed
Patient received a transfus	ion Severe bleeding			
Other serious event (specif	y)			
Duration of event:	2 Hours Da	ys		
7. Remarks: completed	w/ Duc			
	,			
a. Name of physician wh	o provided RU-486		Dr. Gerse	Caras
. b. Physician's signature	- Pilins	0	(MD	you
	Date	7.7.72	17	
end completed forms to:	State Medical Boa	rd of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd Floor		MEDI	CAL DOADE
	Columbus, OH 43215-612	17	יאובטו	CAL BOARD
			Jl	JL 1 9 2017



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	_ 4		18
	Month	Day	Year
2. Name of medical practice or facility at a planned Parenthood	which RU-486 was pro	vided:	
3. Address of medical practice or facility a	t which RU-486 was pr	ovided:	
2314 Auburn Auc.	ana, of	45219	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):		A .	
Incomplete abortion A	dverse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Severe ble	eeding		
Other serious event (specify)			
6. Duration of event: 4 Hours	Days		
7. Remarks: Trial of medicine to with such	out needed D	*C which w	is done
8. a. Name of physician who provided RU	-486	Ma line	
8. b. Physician's signature		M.D	/D.O
	Date	// V	
Send completed forms to: State	Medical Board of Ohio)	
Legal Depart	ment	8 4F-F-17	
30 E. Broad S	St., 3 rd Floor	MEDIC	CAL BOARD
Columbus, O	H 43215-6127	MAY	2 1 2018

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

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	 Month	Day	18
2. Name of medical practice or facility of the presentation of the	ty at which RU-486 was prov		Year
3. Address of medical practice or faci	lity at which RU-486 was pro	ovided:	
2314 Auburn Au			
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 hospitalized	
Patient received a transfusion \(\begin{aligned} \text{Sevential} \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ere bleeding		
Other serious event (specify)			_
6. Duration of event: Hou	urs Days		
7. Remarks: pt. Stuble, Stages	d as , vor		
8. a. Name of physician who provided	i RU-486 (Da line	
8. b. Physician's signature	Date - 5/1/1	M.D./D.O.	
Send completed forms to:	State Medical Board of Ohio		
	epartment		
	oad St., 3 rd Floor	MEDICAL	BOARD
Columb	us, OH 43215-6127	MAY 2	2018



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		28	, ,
·	Month	Day	Year
2. Name of medical practice or facility at v Planned Parenthood	vhich RU-486 was prov	vided:	
3. Address of medical practice or facility at	which RU-486 was pro	ovided:	
2314 Auburn Aus.	ana, of	4.5219	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
A	dverse reaction to RU-486	Patient hospitalized	3
Patient received a transfusion Severe ble	eding		
Other serious event (specify)			
6. Duration of event: 3 Hours	Days		
7. Remarks: completed surpcult	, }		
8. a. Name of physician who provided RU-	486 10 1)	. Kiby	
8. b. Physician's signature	Maly	(MD)	D.O.
	/ Date ————		
Send completed forms to: State	Medical Board of Ohio)	
Legal Depart	ment		-01DD
30 E. Broad S	t., 3 rd Floor	MEDI	CAL BOARD
Columbus, O	H 43215-6127		NY 2 1 2018



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provi	ded:		2 P Day	
2. Name of medical pract		which RU-486 was p		Year
3. Address of medical prac	tice or facility a	t which RU-486 was	provided:	
2314 Aubur	n Ave.	ana, of	1 45219	
4. Date post RU-486 comp	lication began:	క/క	117	
5. Event(s) (Please check a	ll that apply):			and the second s
	A	dverse reaction to RU-48	86 Patient hospita	alized
Patient received a transfusi	onSevere ble	eding		
			٨	MEDICAL BOARD
Other serious event (specify)			MAY 1 2 2017
		,/		L & LUI/
6. Duration of event:	Hours	4 Days		
7. Remarks: pt. retu S+	ind for	DXC 95 day mis	She could was diegn	okc,
8. a. Name of physician who	provided RU-4	186	D. Ci	4
8. b. Physician's signature		Date \$19	1/17	700
Send completed forms to:	State N	Medical Board of Ohi		
	Legal Departm		-	
	30 E. Broad St	., 3 rd Floor		
	Columbus, OH	43215-6127		



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provid	ded:		26	17
		Month	Day	Year
2. Name of medical practi	//	RU-486 was provi	ided:	
3. Address of medical pract	tice or facility at which	RU-486 was pro	vided:	
2314 Aubur				
4. Date post RU-486 compl	ication began:	·		
5. Event(s) (Please check al	that apply):			
Incomplete abortion	Adverse re	eaction to RU-486	Patient hospitalized	:
Patient received a transfusio	n Severe bleeding			
∠Other serious event (specify)	ongoing	pa gna	ncy	
6. Duration of event:	Hours	_ Days		
7. Remarks: Completed S.	ergically wi	thout iss	ché.	
0 - Name of 12 - 12		<u> </u>		
8. a. Name of physician who	provided RU-486	2	c. Gno!	
3. b. Physician's signature	Date	6/14	1/17	
end completed forms to:	State Medical	Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd Flo	oor	MEDICAL BOX	∑ Þ ∏
	Columbus, OH 43215	5-6127	JUN 1 9 2017	
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Prescribed: 5/--/2011, Rev. 12/13/12

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

<u> </u>				
1. Date RU-486 was prov	ided:	5 Month	31 Day	7
2. Name of medical pract Planned Par		RU-486 was prov		Year
3. Address of medical prace 2314 Aubur.				
4. Date post RU-486 comp				
5. Event(s) (Please check a		eaction to RU-486	∠ Patient hospi	talized
Patient received a transfusi Other serious event (specifi				
6. Duration of event:	Hours	_ Days		
7. Remarks:				
8. a. Name of physician wh	o provided RU-486	<i>D</i>	berselan-	~
8. b. Physician's signature	- Pruja Date	Dursah	M	D./D.O
send completed forms to:		Board of Ohio		
	Legal Department 30 E. Broad St., 3 rd Fic Columbus, OH 43215		ME	EDICAL BOARD

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

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provide	d:				17	118,13,13
		Month	D	е у	Year	
2. Name of medical practice		U-486 was pro	vided:			
3. Address of medical practic	e or facility at which	RU-486 was pr	ovided:			
2314 Auburn	Ave. Cin	ci, of	452	19		
4. Date post RU-486 complica フノカロ	ation began:					
5. Event(s) (Please check all t	hat apply):					
Incomplete abortion	Adverse rea	action to RU-486	Patient	hospitalized		
Patient received a transfusion	∠ Severe bleeding					
Other serious event (specify) _					_	
6. Duration of event: 2	Hours	Days			1.	
7. Remarks: Feodwel w/ D	* (.					
3. a. Name of physician who p	rovided RU-486		Dr.	Line		
3. b. Physician's signature				M.D./D.O		
	Date -	8/3	3/17			
end completed forms to:	State Medical I	Board of Ohio				
L	egal Department					
	0 E. Broad St., 3 rd Floo					
C	olumbus, OH 43215-	6127		WEDI	Char ROP	Sel 1

AUG 6 3 2017



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was pro-	vided:	Month	د Day	17
2. Name of medical prac	tice or facility at which RI		•	Year
3. Address of medical pra	actice or facility at which F	RU-486 was nre	wided:	
	n Au. and			
4. Date post RU-486 com				
5. Event(s) (Please check	all that apply):			
Incomplete abortion	Adverse rea	iction to RU-486	Patient hospitalize	d
Patient received a transfus	ion Severe bleeding			
Other serious event (specif	ý)			***************************************
6. Duration of event:	2Hours	Days		
7. Remarks:	us for med			
8. a. Name of physician wh	o provided RU-486		26 6	/
8. b. Physician's signature	(101)	nh	M.D./1	· · · · · · · · · · · · · · · · · · ·
	Date —	8/18/1	7	
Send completed forms to:	State Medical B	oard of Ohio		
	Legal Department		-,	• •
	30 E. Broad St., 3 rd Floo		7F0164	
	Columbus, OH 43215-6	5127	SIE	1 2017

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

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	0	20	_
	Month	20 Day	<i>17</i>
2. Name of medical practice or facility at which F Planned Parenthood	RU-486 was prov	<u> </u>	Year
3. Address of medical practice or facility at which	RU-486 was pro	ovided:	
2314 Auburn Aus. Cin	a, of	45219	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Incomplete abortion Adverse re	eaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe bleeding			
Other serious event (specify) Failed n	udical A	Soltian .	
6. Duration of event: 2 Hours	_ Days		
7. Remarks: Completed Surgically w/o i	15 W		
٠.	% .		
8. a. Name of physician who provided RU-486		D. Lins	
8. b. Physician's signature Date	10/5/1	17 50100	
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

OCT 12 2017

MEDICAL BOARD



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	<u>9</u> Month	21	17
2. Name of medical practice or fa Planned Parenth	cility at which RU-486 was provid	Day ded:	Year
3. Address of medical practice or f			
2314 Auburn A	Luc. ana, of	45219	
4. Date post RU-486 complication			
5. Event(s) (Please check all that a	oply):		
Incomplete abortion	Adverse reaction to RU-486	Patient hospitalized	d ·
Patient received a transfusion S	evere bleeding		
Other serious event (specify)	failed med A	lo	
tratmelet 6. Duration of event: H	ours Days		
7. Remarks:			
a. Name of physician who provide	ad DI 196) /) /	
b. Physician's signature	10-400	KIRIT	
	Date)	
end completed forms to:	State Medical Board of Ohio		
	epartment		
	road St., 3 rd Floor	4 A	
Columb	ous, OH 43215-6127	141	EDICAL BOAR

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

OCT 06 2017



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided		0	17	17
		Month	Day	Year
2. Name of medical practice Planned Paren		U-486 was provi	ded:	
3. Address of medical practice	or facility at which I	RU-486 was pro	vided:	
2314 Auburn	Au. an	a, of	45219	
4. Date post RU-486 complica	tion began:			
5. Event(s) (Please check all th	nat apply):			
Incomplete abortion	Adverse rea	action to RU-486	Patient hospitalized	
Patient received a transfusion	Severe bleeding			
Other serious event (specify)	on going of	ne france		***************************************
6. Duration of event: 3	Hours	Days		
7. Remarks:	durgially			
3. a. Name of physician who pr	ovided RU-486		r. P.chil	
3. b. Physician's signature		(n		0.0
	Date –	0'	Hio	118
end completed forms to:	State Medical E	Board of Ohio		
Le	gal Department			
30	E. Broad St., 3 rd Floo	or		
Co	olumbus, OH 43215-	6127	MEDIC	CAL DOADD

FEB 0.5 2018



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was pro	(All Section 1 and the second section 1) and the second section (1) and the section (1) and the second section (1) and the section (1) a	/0	19	12-
		Month	Day	Year
2. Name of medical practical practic	ctice or facility at which Ri Mnthood	J-486 was provid	ed:	
3. Address of medical pra	actice or facility at which F	RU-486 was provi	ded:	
1	n Aue. and			
4. Date post RU-486 com	plication began:			
5. Event(s) (Please check	all that apply):			
Incomplete abortion	Adverse rea	ction to RU-486	Patient hospitalized	·
Patient received a transfus	ion Severe bleeding			• • • • • • • • • • • • • • • • • • • •
Other serious event (specif	N) Continued	ore juning		
6. Duration of event:	Hours 2	Days		
7. Remarks: pt. had to	ermention con	spected su	jalls.	
. a. Name of physician wh	o provided RU-486	12.2		
. b. Physician's signature	Date	12/6/	MD/D	Δ
end completed forms to:	State Medical Bo			
	30 E. Broad St., 3 rd Floor		· .	
	Columbus, OH 43215-63		MEDIC	AL BOARD
		***		1 5 2017

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

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provid				
	ea:			12
2 Name of modical and the		Month	Day	Year
2. Name of medical practice Planned Park	e or facility at which	n RU-486 was prov	ided:	
3. Address of medical practi	ce or facility at which	h DII 490		
2314 Auburn				
4. Date post RU-486 complic	ation began:	129/17		
5. Event(s) (Please check all t	hat apply):	2-1111		
Incomplete abortion		reaction to RU-486	Patient hospitalized	
Patient received a transfusion	Severe bleeding			
$ ot\!$	ingoing,	pre grancy		-
5. Duration of event:/	Hours	_ Days		
7. Remarks:				
Completed o	pu fically.			
a. Name of physician who pr	ovided RU-486			
b. Physician's signature	_		r. Far	
	Date	12/11	/12 MB/00	
nd completed forms to:	State Medical	Board of Ohio		
Le	gal Department			
30	E. Broad St., 3 rd Flo	or		
Co	lumbus, OH 43215	-6127	MEDICA	AL BOARD

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

DEC 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	led:	1.2	2	. 7
		Month	Day	Year
2. Name of medical practic	e or facility at which RU Inthood	J-486 was prov	rided:	
3. Address of medical pract	ice or facility at which R	U-486 was pro	ovided:	
2314 Auburr				
4. Date post RU-486 compli 12/2//17				
5. Event(s) (Please check all	that apply):			
incomplete abortion	Adverse rea	ction to RU-486	Patient hospitalize	d
Patient received a transfusion	Severe bleeding			
Other serious event (specify)				· ·
. Duration of event:2	7Hours [Days		
. Remarks:				
a. Name of physician who p	provided RU-486	D-	Liv-	
b. Physician's signature	- that		M.D./1	0.0
	Date —	12/26/	1,7	
nd completed forms to:	State Medical Bo	oard of Ohio		
	egal Department			
	80 E. Broad St., 3 rd Floor		MEDIO	CAL BOARD
(Columbus, OH 43215-6	127	AI.	N 0 9 2018

MEDICAL SCHAP

JAN 27 2017



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-485

1 Date RIL-486 ups provide 1			
1. Date RU-486 was provided:	•	3	17
2 Name of modical and	Month	Day	Year
2. Name of medical practice or face Planned Parenthe	cility at which RU-486 was p	rovided:	
3. Address of medical practice or fa	acility at which RU-486 was	provided:	
2314 Auburn A			
4. Date post RU-486 complication b	oegan: 1 1 7 1 7	L	
5. Event(s) (Please check all that ap	ply):		
Incomplete abortion	Adverse reaction to RU-48	36 Patient hospitalized	
Patient received a transfusion Se	vere bleeding		
Other serious event (specify)	infection		
6. Duration of event: Ho	ours // Days		
7. Remarks: fasponcles is ili	to antibiot	7 ()°	
. a. Name of physician who provide	d RU-486	DI Pick	60
. b. Physician's signature		0,00	4
	Date	2 V	<u> </u>
end completed forms to:	State Medical Board of Ohio	>()	
Legal De	epartment		
30 E. Bri	oad St., 3 rd Floor		
Columb	us, OH 43215-6127		