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-486

1. Date RU-486 was provided: 01 (Month) 09 (Day) 2017 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 East Main St., Columbus, Ohio 43213

4. Date post RU-486 complication began: 1/23/17

5. Event(s) (Please check all that apply):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: _____ Hours 14 Days

7. Remarks:
D+C after incomplete Medication Abortion

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 1/30/17

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

MEDICAL BOARD
FEB 01 2017

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

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-486

1. Date RU-486 was provided: 1 (Month) 19 (Day) 2017 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 East Main St., Columbus, Ohio 43213

4. Date post RU-486 complication began: 1/30/17

5. Event(s) (Please check all that apply):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: _____ Hours 11 Days

7. Remarks:
Incomplete MAB requiring D&C

8. a. Name of physician who provided RU-486 Catherine Romanes

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

Date 2/21/17

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

MEDICAL BOARD
FEB 22 2017

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

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-486

1. Date RU-486 was provided: 2 (Month) 6 (Day) 2017 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 East Main St., Columbus, Ohio 43213

4. Date post RU-486 complication began: 2/14/17

5. Event(s) (Please check all that apply):

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed Medication Abortion

6. Duration of event: _____ Hours 8 Days

7. Remarks: Failed Medication Abortion requiring surgical D+C

8. a. Name of physician who provided RU-486 Ramirez

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

Date 2/21/17

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

MEDICAL BOARD
FEB 22 2017

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

9

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-486

1. Date RU-486 was provided: 2 (Month) 23 (Day) 17 (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 provided:
3255 East Main St Columbus OH

4. Date post RU-486 complication began:
3/2/17

5. Event(s) (Please check all that apply):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: _____ Hours 7 Days

7. Remarks: Med AB incomplete MISO repeat dosing.

8. a. Name of physician who provided RU-486 Romano

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

Date 3/7/17

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

MEDICAL BOARD
MAR 17 2017

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

10

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-486

1. Date RU-486 was provided: 03 (Month) 30 (Day) 2017 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood east surgical center

3. Address of medical practice or facility at which RU-486 was provided:
3255 East main St, Columbus OH, 43213

4. Date post RU-486 complication began: 4/3/17

5. Event(s) (Please check all that apply):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: _____ Hours 5 Days

7. Remarks:
D&C performed, uncomplicated.

8. a. Name of physician who provided RU-486 Catherine Romano

8. b. Physician's signature _____ MD/DO

Date 4/4/17

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

MEDICAL BOARD
APR 07 2017

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

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-486

1. Date RU-486 was provided: 04 (Month) 13 (Day) 2017 (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 provided:
3255 E. main St, Columbus OH 43213

4. Date post RU-486 complication began:
4/28/17

5. Event(s) (Please check all that apply):

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed Abortion

6. Duration of event: _____ Hours 15 Days

7. Remarks:

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

8. b. Physician's signature A. Lowther, MD (M.D./D.O)

Date 5/11/17

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

MEDICAL BOARD
MAY 16 2017

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

12

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-486

1. Date RU-486 was provided: April 24 2017
   Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
   Planned Parenthood East Surgery Center

3. Address of medical practice or facility at which RU-486 was provided:
   3255 E. Main St. Columbus, OH 43213

4. Date post RU-486 complication began:
   5/1/17

5. Event(s) (Please check all that apply):

   X Incomplete abortion
   ___ Adverse reaction to RU-486
   ___ Patient hospitalized
   ___ Patient received a transfusion
   ___ Severe bleeding
   ___ Other serious event (specify) _____

MEDICAL BOARD
MAY 12 2017

6. Duration of event: N/A Hours _____ Days

7. Remarks:
   Incomplete MAB, D&C performed 5/9/17

8. a. Name of physician who provided RU-486 Romanos

8. b. Physician's signature _____ MD DO

Date 5/9/17

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

MEDICAL BOARD
MAY 12 2017

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

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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-486

1. Date RU-486 was provided: June (Month) 1 (Day) 2017 (Year)

2. Name of medical practice or facility at which RU-486 was provided: East Surgery Ctr. Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided: 3255 E. main St. Columbus, OH 43213

4. Date post RU-486 complication began: 6/9/17

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: _____ Hours _____ Days

7. Remarks: Patient had aspiration on 6/9/17

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 6/14/17

Send completed forms to: State Medical Board of Ohio
Legal Department
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Columbus, OH 43215-6127

MEDICAL BOARD
JUN 19 2017

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

14

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-486

1. Date RU-486 was provided: June (Month) 7 (Day) 2017 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 E Main St. Columbus, OH 43213

4. Date post RU-486 complication began:
6/21/17 at MAB follow up

5. Event(s) (Please check all that apply):

✓ failed ___ Incomplete abortion ___ 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:
Surgical AB after medical AB on 6/22/17

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 6/27/17

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

MEDICAL BOARD
JUN 28 2017

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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-486

1. Date RU-486 was provided: June 13 (26 error) 2017
   Month Day Year

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

3. Address of medical practice or facility at which RU-486 was provided:
   3255 E. Main St. Columbus OH 43213

4. Date post RU-486 complication began:
   June 26, 2017

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 _____ Days

7. Remarks:
   6/26 - Surgical AB after incomplete Med AB

8. a. Name of physician who provided RU-486 Catherine Ramanes

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

Date 6/22/17 error 6/27/17

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

MEDICAL BOARD
JUN 28 2017

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

14

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-486

1. Date RU-486 was provided: 6 (Month) 23 (Day) 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus, OH 43213

4. Date post RU-486 complication began: 7/3/17

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) Failed MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks: Suction on 7/3/17 at MAB Follow up appt.

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 7/5/17

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

MEDICAL BOARD
JUL 10 2017

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

17

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-486

1. Date RU-486 was provided: July (Month) 3 (Day) 2017 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St. Columbus, OH 43213

4. Date post RU-486 complication began:
7/10/17

5. Event(s) (Please check all that apply):

X Incomplete abortion
___ 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:

8. a. Name of physician who provided RU-486 Catharine Romanos

8. b. Physician's signature _____ MD/DO

Date 7/12/17

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

MEDICAL BOARD
JUL 13 2017

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

16

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-486

1. Date RU-486 was provided: 07 (Month) 07 (Day) 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
12000 Shaker Blvd. Cleveland 44120

4. Date post RU-486 complication began: 07/21/17

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 Mitchell Reiter, M.D.

8. b. Physician's signature _____ MD/DO

Date 8/2/17

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

MEDICAL BOARD
AUG 07 2017

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

19

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-486

1. Date RU-486 was provided: 7 (Month) 28 (Day) 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 3255 E Main St. Columbus, OH 43213

4. Date post RU-486 complication began: 8/4/17

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 Michelle Isley

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

Date 8/11/17

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

MEDICAL BOARD
AUG 16 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-486

1. Date RU-486 was provided: 8 (Month) 16 (Day) 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 3255 E Main St. Columbus, OH 43213

4. Date post RU-486 complication began: 8/21/17

5. Event(s) (Please check all that apply):

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks: Dilation and suction - uncomplicated.

8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature _____ MD/DO

Date 8/22/17

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

MEDICAL BOARD
AUG 24 2017

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

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-486

1. Date RU-486 was provided: 8 (Month) 28 (Day) 17 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood East Surgery Ctr.

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St. Columbus, OH 43213

4. Date post RU-486 complication began: 9/7/17

5. Event(s) (Please check all that apply):

- [X] Incomplete abortion
- [ ] 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:
uncomplicated suction procedure

8. a. Name of physician who provided RU-486 Catherine Romanes

8. b. Physician's signature _____ MD/DO

Date 9/21/17

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

MEDICAL BOARD
SEP 2 3 2017

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

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-486

1. Date RU-486 was provided: 9 (Month) 15 (Day) 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus, OH 43213

4. Date post RU-486 complication began: 9/25/17 at follow up

5. Event(s) (Please check all that apply):

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) failed MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Michelle Isley

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

Date 10/6/17

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

MEDICAL BOARD
OCT 11 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-486

1. Date RU-486 was provided: 9 (Month) 18 (Day) 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St. Columbus, OH 43213

4. Date post RU-486 complication began:
9/22/17

5. Event(s) (Please check all that apply):

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) failed Medication abortion

6. Duration of event: _____ Hours _____ Days

7. Remarks:
uncomplicated suction

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 9/25/17

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

MEDICAL BOARD
SEP 28 2017

Prescribed: 5/-Jon1, Rev 12/13/12

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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-486

1. Date RU-486 was provided: 9 (Month) 21 (Day) 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 3255 E Main St. Columbus, OH 43213

4. Date post RU-486 complication began: 9/25/17

5. Event(s) (Please check all that apply):

X Incomplete abortion

___ 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: Incomplete D&C

8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature _____ MD/DO

Date 9/27/17

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

MEDICAL BOARD
SEP 28 2017

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

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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-486

1. Date RU-486 was provided: Sept (Month) 25 (Day) 2017 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 E Main St. Columbus, OH 43213

4. Date post RU-486 complication began:
10/3/17

5. Event(s) (Please check all that apply):

X Incomplete abortion
___ 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: Incomplete D&C

8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature _____ MD/DO

Date 10/16/17

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

MEDICAL BOARD
OCT 23 2017

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

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-486

1. Date RU-486 was provided: Oct. (Month) 9 (Day) 2017 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 E Main St. Columbus, OH 43213

4. Date post RU-486 complication began:
10/13/17

5. Event(s) (Please check all that apply):

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) failed MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature _____ MD/DO

Date 10/16/17

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

MEDICAL BOARD
OCT 18 2017

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

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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-486

MEDICAL BOARD
NOV 03 2017

1. Date RU-486 was provided: 10 (Month) 11 (Day) 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St.
Columbus OH 43213

4. Date post RU-486 complication began:
10/31/17

5. Event(s) (Please check all that apply):

X Incomplete abortion
___ 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:
uncomplicated D&C

8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature _____ MD/DO

Date 10/31/17

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

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-486

1. Date RU-486 was provided: Oct (Month) 16 (Day) 2017 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood East Surgery Center

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St.
Columbus OH 43213

4. Date post RU-486 complication began:
11/22/17

5. Event(s) (Please check all that apply):

X Incomplete abortion
___ 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:
uncomplicated D&C

8. a. Name of physician who provided RU-486 Catherine Romanos MD/DO

8. b. Physician's signature _____ Date 11/28/17

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

MEDICAL BOARD
NOV 30 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-486

1. Date RU-486 was provided: Oct (Month) 18 (Day) 2017 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus, OH 43213

4. Date post RU-486 complication began: 10/23/17

5. Event(s) (Please check all that apply):

- [X] Incomplete abortion
- [ ] 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: uncomplicated DC

8. a. Name of physician who provided RU-486 Catharine Romanos

8. b. Physician's signature _____ MD/DO

Date 12/25/17

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

MEDICAL BOARD
OCT 30 2017

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

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-486

1. Date RU-486 was provided: 10 (Month) 18 (Day) 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St.
Columbus OH 43213

4. Date post RU-486 complication began:
10/25/17

5. Event(s) (Please check all that apply):

X Incomplete abortion
___ 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:
uncomplicated D&C

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 11/2/17

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

MEDICAL BOARD
NOV 06 2017

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

31

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-486

1. Date RU-486 was provided: Nov (Month) 9 (Day) 2017 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St.
Columbus OH 43213

4. Date post RU-486 complication began: 11/17/17

5. Event(s) (Please check all that apply):

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed MtB

6. Duration of event: _____ Hours _____ Days

7. Remarks:
Uncomplicated Suction

8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature _____ MD/DO

Date 11/21/17

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

MEDICAL BOARD
NOV 24 2017

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

32

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-486

1. Date RU-486 was provided: 11 (Month) 20 (Day) 17 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood East Surgery Ctr.

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St.
Columbus OH 43213

4. Date post RU-486 complication began: 11/30/17

5. Event(s) (Please check all that apply):

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) failed MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks:
uncomplicated D&C

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 12/15/17

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

DEC 13 2017

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