State Medical Board of Ohio

Report of RU-486 Event

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 01 (Month) 26 (Day) 2018 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
1160 W. Sylvania Ave.
Toledo, OH 43612

4. Date post RU-486 complication began:
02/20/2018

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: 4 Hours Ø Days

7. Remarks: Incomplete Med. Abs. D&C completed. K complications

8. a. Name of physician who provided RU-486 Dr. L. Ann Nunnally

8. b. Physician's signature L. A. Nunnally MD M.D/D.O___

Date 02/20/2018

Send completed forms to:

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

MEDICAL BOARD
APR 13 2018

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 02 (Month) 28 (Day) 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
1100 W Sylvania Ave
Toledo OH 43612

4. Date post RU-486 complication began:
3/9/17

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 1 Days

7. Remarks:
Pt in for surgical (D+C) after incomplete Med AB. Ø complications

8. a. Name of physician who provided RU-486 Dr David Burkons MAA1224

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

Date 03/09/18

Send completed forms to:

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

MEDICAL BOARD

State Medical Board of Ohio

Report of RU-486 Event

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 04 (Month) 27 (Day) 2018 (Year)

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

Capital Care Network of Toledo

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

1160 W. Sylvania Ave.

4. Date post RU-486 complication began:

06-02-18

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: 5 Hours ____ Days

7. Remarks: Incomplete MAB ab. pt requests d+c. D+C completed. ✓ Complications

WIK0819

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

8. b. Physician's signature X. A. Nally MD M.D./D.O.___

Date 06/02/18

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

JUN 11 2018

State Medical Board of Ohio

Report of RU-486 Event

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 05 (Month) 10 (Day) 2018 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
1160 W. Sylvania Ave Toledo OH 43612

4. Date post RU-486 complication began:
05/23/2018

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 Medical Abortion

6. Duration of event: _____ Hours 2 Days

7. Remarks: Surgical abortion completed on 05/25/2018.

GUK0730

8. a. Name of physician who provided RU-486 Dr. Lucy Ann Nunnally

8. b. Physician's signature Lucy Nunnally MD (M.D/D.O)

Date 5/25/18

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

JUN 11 2018

6

State Medical Board of Ohio

Report of RU-486 Event

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 05 (Month) 07 (Day) 18 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
1160 W. Sylvania Ave. Toledo, OH 43612

4. Date post RU-486 complication began:
06/12/18

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: 2 Hours _____ Days

7. Remarks: Incomplete Med. AB. D+C completed. ∅ complications
NOA 0927

8. a. Name of physician who provided RU-486 Dr. L. Ann Nunnally

8. b. Physician's signature L. Ann Nunnally MD (M.D/D.O)

Date 06/12/18

Send completed forms to:

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

MEDICAL BOARD
JUN 26 2018