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

1. Date RU-486 was provided:	13	م) (ب	2018	
1 7	Month	Day	Year	
2. Name of medical practice or facility	at which RU-486 was provide	d:		
Capital Care We	two-le Toledo			
3. Address of medical practice or 1160 W. Sylvan Ka Toleko, OH YBbla	facility at which RU-486 wa	is provided:		
4. Date post RU-486 complication 02 / 20 / 20 と	began:			
5. Event(s) (Please check all that a	apply):			
Incomplete abortion	Adverse reaction to RU-486	Patient hospitalized		
Patient received a transfusion Sev	ere bleeding			
Other serious event (specify)				
6. Duration of event: 4 Hou	rs Days			
7. Remarks: Jucumete N	ud An. DEC	compreted, &	a complicate	-~ _{
The fact in	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	•	3	-
8. a. Name of physician who prov	rided RU-486	L.Am De	innally	
8. b. Physician's signature			_M.D/D.O	
	Date <u> </u>	20/2018		
Send completed forms to:	State Medical B	oard of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd Floo	MEC	DICAL BUZZA	
	Columbus, OH 43215-6	5127 <i>ļ</i>	APR 1.3 20:8	

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	02	ିଟ୍	177
	Month	Car &.	Year Year
2. Name of medical practice or facility at which	RU-486 was prov	ided:	
Captel Cruze Network	Taledo		
2 Address of modical and in Call			
3. Address of medical practice or facility a	it which RU-486	was provided:	
			·
1 Pate post PILLARS on - Booting			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
	e reaction to RU-486	Patient hospitalize	d
	• 1		
Patient received a transfusion Severe bleeding	g		
Other serious event (specify)			
_			
6. Duration of event: Hoursi	Days		
7.0			
7. Remarks:	· incomple	to Med 46.	of complications
_			
0		-/-//	MAA1224
8. a. Name of physician who provided RU-	486 <u>D.j.</u>	Wivid Burk	C. C
8. b. Physician's signature	1) /	1	(M.D/D.O
	Date 031	<u> ७९१।४</u>	
iend completed forms to:	State Medical	Board of Ohio	
Logali			
	Department		
30 E. I	Broad St., 3rd Flo	or	
Colum	bus, OH 43215	6127	• 12mm
			MEDICAL BOARD
			£
			9

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	04	27	2018
	Month	Day	Year
Name of medical practice or facility at wh	nich RU-486 was prov	ided:	
Capital Care Wetwork of	f Tolecto		
3. Address of medical practice or facilit	ty at which RU-486	was provided:	
1160 W. Sylvania Av	6. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.		
4. Date post RU-486 complication bega のしっりユーレク	an:		
5. Event(s) (Please check all that apply)):		
Incomplete abortionAd	verse reaction to RU-486	Patient hospitali	zed
Patient received a transfusionSevere blee	eding		
Other serious event (specify)			
6. Duration of event: 5 Hours	Days		
7. Remarks: Incomplete med Dic completed;	ab. pt regulation	ists dtc.	
Off constants	ing the second of the second o		WIK0819
8. a. Name of physician who provided	,RU-486	///	
8. b. Physician's signature	(+ / fol	ly MD	(M.D/D.O

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

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 05 10 2018
Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:
Capital (are Network Toledo
3. Address of medical practice or facility at which RU-486 was provided:
1160 W. Sylvania Are Toledo OH 43612
4. Date post RU-486 complication began: 05 (23 2018
5. Event(s) (Please check all that apply):
Adverse reaction to RU-486 Patient hospitalized
Incomplete abortion Adverse reaction to RU-486 Patient hospitalized
Patient received a transfusion Severe bleeding
Other serious event (specify) Failed Medical Abartion
6. Duration of event: Hours Days
7. Remarks: Surgical abortion completed on 05/25/2018.
05/25/2018.
GUK0730
8. a. Name of physician who provided RU-486 Dr. Lucy And Nuncelly
8. b. Physician's signature Date 5/25/18 M.D/D.O
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

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

1. Date RU-486 was provided:	O 5	07 Day	Year
Name of medical practice or facility at			
Capital Core Wetwo	ork of Toled	0	
	The studied BILASS	was provided:	
3. Address of medical practice or fa	Ave. Toledo,	OH 43612	
4. Date post RU-486 complication to 06/12/18	egan:		
5. Event(s) (Please check all that ap	ply):		
Incomplete abortion _	Adverse reaction to RU-486	Patient hospitaliz	e d
+ monspect assume			
Patient received a transfusion Sever	e bleeding		
Other serious event (specify)			
6. Duration of event: 2 Hours	Days		
			atical and
7. Remarks: Incomplete N	ud, AB, btc	Coupleta	. \$ complications
			NOA 6927
C. L. who mrou	datellass Dr	La Arm N	lunnally
8. a. Name of physician who provi 8. b. Physician's signature	Nut /	elly MD	(M.D)/D.O
	Date 06	12/10	
Send completed forms to:	State Medic	cal Board of Ohio	
	Legal Department		
	30 E. Broad St., 3 rd F	loor	
	Columbus, OH 432		MEDICAL BOARD

JUN 2 6 2018