

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was prov	vided:	3	11		17	
		Month	Day		Year	
2. Name of medical prac		ich RU-486 was prov	vided:			
3. Address of medical pra	ctice or facility at w	hich RU-486 was pro	wided:			
2314 Aubur						
4. Date post RU-486 com	olication began:					***************************************
5. Event(s) (Please check a	all that apply):					
Incomplete abortion	Adve	rse reaction to RU-486	Patient hospi	talized		
Patient received a transfus	ion Severe bleedin	g g				
Other serious event (specif	y)					
6. Duration of event:	2 Hours	Days				
7. Remarks: Ĵ∀ (Ø	ion without	inandent				
s. a. Name of physician wh	o provided RU-486		0, 6			
. b. Physician's signature		5. 2	M	200		
	Da	ate4//	5/17	,		
end completed forms to:	State Med	ical Board of Ohio				
	Legal Department	:				
	30 E. Broad St., 3"	floor		MEDIC	AL BO	ARD
	Columbus, OH 43	215-6127		APR	14 20	17

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 provided:		4	5	18
		Month	Day	Year
2. Name of medical practice or f	. 7	RU-486 was prov	rided:	
3. Address of medical practice or	facility at which	RU-486 was pro	ovided:	
2314 Auburn,	Au. an	ia, of	45219	
4. Date post RU-486 complication	n began:			
5. Event(s) (Please check all that	apply):			
Incomplete abortion	Adverse re	eaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion	Severe bleeding			
Other serious event (specify)				
6. Duration of event:	+M Hours	_ Days		
7. Remarks:				
trial of midic	Succes	rudul D.	IC which w	is done
8. a. Name of physician who prov	vided RU-486		Ma line	
8. b. Physician's signature			M.D	/ D.O
_	Date	116,	1,0	
Send completed forms to:	State Medica	al Board of Ohio		
Lega	al Department		N 4E D 1 C	
30 E	. Broad \$t., 3 rd F	loor	MEDIC	CAL BOARD
Colu	ımbus, OH 4321	5-6127	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-485

1. Date RU-486 was provid	ied:	_4		18
		Month	Day	Year
2. Name of medical practi	ce or facility at which	RU-486 was prov	ided:	
Planned Par-	enthood			
3. Address of medical prac	tice or facility at whic	h RU-486 was pro	vided:	
2314 Aubur	n Aur. a)	na, of	45219	
4. Date post RU-486 comp	ication began:			
5. Event(s) (Please check a	l that apply):			
Incomplete abortion	Adverse	reaction to RU-486	Patient hospitalized	
Patient received a transfusion	on ∠Severe bleeding			
Other serious event (specify)			
6. Duration of event:	Hours	Days		
7. Remarks: pt. Stuble,	Stated on	VOL		
8. a. Name of physician wh	o provided RU-486		Dr. line	
8. b. Physician's signature	1/12		M,D/ D	Δ
	Dat	te <i>5/1/1</i> 5	7	
Send completed forms to:	State Medio	cal Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd	Floor	MEDICA	AL BOARD
	Columbus, OH 432	15-6127	ΜΔΥ	2 1 2018

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



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provid	led:	Month	28	17	
2. Name of medical practi			Day ided:	Year	
3. Address of medical pract					
4. Date post RU-486 compl		5/5/			
5. Event(s) (Please check all	that apply):				
	Adverse read	ction to RU-486	Patient hospitali:	zed i i i i i i i i i i i i i i i i i i i	
Patient received a transfusio	n Severe bleeding		M	EDICAL DE	
Other serious event (specify)			4415	EDICAL BOAR	C
				MAY 1 2 2017	
6. Duration of event:	Hours[Days			
7. Remarks: pt. retu: St.	ind for Dx	C 95 This w	the could as diagno.	not	
8. a. Name of physician who	provided RU-486		D. Lin	/	
8. b. Physician's signature	Date —	J9/1	() () () () () ()	¹ D.O	
Send completed forms to:	State Medical B	oard of Ohio			
	Legal Department				
	30 E. Broad St., 3 rd Floo	r			
	Columbus, OH 43215-6	127			



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:		26	17
2. Name of modical assetication of all	Month	Day	Year
2. Name of medical practice or facility		ovided:	
- Planned Parenthood	<u>X</u>		
3. Address of medical practice or facili	ty at which RU-486 was p	provided:	
2314 Auburn Aus	. ana, ot	45219	
4. Date post RU-486 complication bega	an:		
5. Event(s) (Please check all that apply)	:		
Incomplete abortion	Adverse reaction to RU-48	6 Patient hospitalized	
Patient received a transfusion Severe	e bleeding		
Other serious event (specify) On C	going page	Vancy	_
6. Duration of event: Hours	Days		
7. Remarks:			
completed surgical	'n without is	Suse	
,	<i>V</i>		
3. a. Name of physician who provided R	U-486	Dr. Line	
3. b. Physician's signature		140 /00	
•	Date	14/17	
end completed forms to: Star	te Medical Board of Ohio		
Legal Depa		,	
	St., 3 rd Floor	MEDICAL SO	n D en
	OH 43215-6127	Made and and	ve, s = 1
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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-485

1. Date RU-486 was prov	ided:	Month	∫ C Day		7
2. Name of medical prac	tice or facility at which RL enthool	J-486 was prov	·	Ye Ye	ar N
3. Address of medical pra	ctice or facility at which R	U-486 was pro	ovided:		
	Au. Cina				
4. Date post RU-486 comp コノカ					
5. Event(s) (Please check a	ıll that apply):				
Incomplete abortion		ction to RU-486	Patient hos	pitalized	
Patient received a transfusi	on \mathcal{L} Severe bleeding				
Other serious event (specifi	/ ያ				
6. Duration of event:	2Hours	Days			
7. Remarks: Revolved w/	0 * (·				
	•				
3. a. Name of physician wh	o provided RU-486		Dr. 6	inc	
B. b. Physician's signature			N	10 /00	
	Date —	8/3	117		
end completed forms to:	State Medical B	pard of Ohio			
	Legal Department				
	30 E. Broad St., 3 rd Floo				
	Columbus, OH 43215-6	127		MEDICA	- 2075an

AUG 0 8 2017



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	0	10	
	9 Month	20 Day	
2. Name of medical practice or facility at which Planned Parenthood			Year
3. Address of medical practice or facility at which	n RU-486 was nro	vided:	
2314 Auburn Aus. Cit			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Incomplete abortion Adverse r	reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe bleeding			
Other serious event (specify) Failed y	nedicol A	201tian	
6. Duration of event: 2 Hours	_ Days		
7. Remarks: Completed Surgically w/o	isu		
٠.	₩ww.com		
8. a. Name of physician who provided RU-486		D. Lins	
8. b. Physician's signature Date		17 10	0
Send completed forms to: State Medica	l Board of Ohio		
Legal Department	. Dodie of Otho		

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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

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MEDICAL BOARD

OCT 12 2017



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was prov	ided:	9	21	17
		Month	Day	Year
2. Name of medical pract		J-486 was provid	ed:	
3. Address of medical pra	ctice or facility at which F	RU-486 was provi	ded:	
2314 Aubur	n Au. and	a, of	45219	
4. Date post RU-486 comp	olication began:			
5. Event(s) (Please check a	ill that apply):			
Incomplete abortion	Adverse rea	ction to RU-486	Patient hospitalized	
Patient received a transfusi	on Severe bleeding			
C Other serious event (specifi	n <u>failed</u>	med A	la	
free 6. Duration of event:/	Hours	Days		
7. Remarks:				
	١,			
8. a. Name of physician wh	o provided RU-486		Jr. Link	
8. b. Physician's signature			MQ/1	20
	Date —	11/8/11)	
Send completed forms to:	State Medical B	oard of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd Floo		7.	IEDICAL DOADE
	Columbus, OH 43215-6	5127	10	IEDICAL BOAR!

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

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OCT 06 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:		D	19	12
_		Moi		Day	Year
2. Name of medical prairies Planned Pa	ctice or facility a	t which RU-486	was provided:		
3. Address of medical pra	actice or facility	at which RU-486	was provided	1	
2314 Aubur					
4. Date post RU-486 com メルト	plication began:				
5. Event(s) (Please check	all that apply):				
Incomplete abortion	- · ·	Adverse reaction to	RU-486P	atient hospitalized	
Patient received a transfüs	sion Severe bl	eeding			
Other serious event (speci	M <u>Contin</u>	ned pref	mmy.		
5. Duration of event:	Hours _	2 Days			
P. Remarks: pt. hid t	termentio.	- Comple	tel surg	call.	
	٧.		***	e e	
a. Name of physician wh	o provided RU-	486	D Lilv.		
b. Physician's signature	-	Date	11/6/17	M.D./D.	0
nd completed forms to:	State I	Medical Board o	f Ohio		
			-		
	Legal Departn	nent			
	Legal Departn 30 E. Broad St				AL BOARD

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



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To be completed by the physician who provided RU-486

1. Date RU-486 was provi	ded:			
	तात्त्रि । प्राप्त	/_ Month		17
2. Name of medical pract	ice or facility at whic Lnthool		Day vided:	Year
3. Address of medical prac	tice or facility at whi	ch RU-486 was pro	vided:	
2314 Aubur				
4. Date post RU-486 compl		129/17		
5. Event(s) (Please check al				
Incomplete abortion	Adverse	reaction to RU-486	Patient hospitalized	
Patient received a transfusio	nSevere bleeding			
$ ot\!$	a sping	pregnancy		
5. Duration of event:	/Hours	Days		
7. Remarks: Campletrel	su gially.			
.a. Name of physician who	provided RU-486		Dr. King	
.b. Physician's signature	Date	- 12/11	1/12	n
end completed forms to:		Board of Ohio	777	
	Legal Department	in positi OI ONIO		
	30 E. Broad St., 3 rd F	loor		
	Columbus, OH 4321		MEDIC	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-485

1. Date RU-486 was provided:		12	2	1.7
		Month	Day	Year
2. Name of medical practice or farentle	acility at which RU	-486 was prov	rided:	
3. Address of medical practice or	facility at which RI	J-486 was pro	vided:	
2314 Auburn ,	tue. and	i, of	45219	
4. Date post RU-486 complication 12/21/17	began:			
5. Event(s) (Please check all that a	pply):		**************************************	
Incomplete abortion	Adverse reac	tion to RU-486	Patient hospitalize	ed
Patient received a transfusion P	Severe bleeding			
6. Duration of event:2	HoursD	ays		
7. Remarks:	,	-		
a. Name of physician who provide	led RU-486	D-	- Lv-	
b. Physician's signature	Date —	12/26,	// 7	D.O
end completed forms to:	State Medical Bo			
Legal	Department			
	Broad St., 3 rd Floor		MEDI	CAL BOARD
Colum	ibus, OH 43215-6:	127	J	AN 09 2018

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

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