(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provid	led:	March	27	2011
3/2/17		Month	Day	Year
2. Name of medical practic	ce or facility at which RU	-486 was provided:		
North	east Chic	My men's	Port	21
3. Address of medical pract	ice or facility at which R	U-486 was provided:		
	tate RA	(1/2)	14000	
4. Date post RU-486 compl	Ga Fa 1/5,	Chia i	14423	
4. Date post No-480 compi	cation began:			
5. Event(s) (Please check al	that apply			
5. Event(s) (Flease check all	гитас арргуу:			
Incomplete abortion	Adverse rea	ction to RU-486 Pat	ient hospitalized	
Patient received a transfusio	n Severe bleeding			
Other serious event (specify)				
6. Duration of event:	3 Hours	Days		

7. Remarks: A	ad () + C	withou	1 Con	introtan
	,,		, () "	
0 a Nama of physician who		, h		11.
8. a. Name of physician who	provided KU-486	L. Mnn N	A Nua 1	19
8. b. Physician's signature		4771	/MD/D	0 / 1/2
	Date -	start-	ulfry Mi) 5/24/1+
Send completed forms to:	State Medical E	Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd Floo	or		
	Columbus, OH 43215-		WED SO	PONTAIN
	,	·	vi∧Y 3	e 2000

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		7	13	2017
		Month	Day	Year
2. Name of medical practice or fa			ded:	
3. Address of medical practice or 1				
4. Date post RU-486 complication	began:			
5. Event(s) (Please check all that a	pply):			
Incomplete abortion	Adverse r	eaction to RU-486	Patient hospitalize	d
Patient received a transfusionS Other serious event (specify)	Severe bleeding			
6. Duration of event: F	· · · · · · · · · · · · · · · · · · ·			
7. Remarks: Pt. had (+) Neuvy bloeding and but pregnancy was	ptu pos on utt resolved.	t Medicati ra Sound the pt had	un Aborgtion are was re a DEC or	n. She had maining tusue 18/22/17
8. a. Name of physician who provic	led RU-486	gr. to	A. Nunnally	
8. a. Name of physician who provices. b. Physician's signature	Date	a>1/1/	MD/	D.O
Send completed forms to:	State Medica	Board of Ohio		
Legal	Department			
30 E. I	Broad St., 3 rd Fl	oor		
	nbus, OH 4321		MEDICA	i BOARD

SEP 1 5 2017

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

1. Date RU-486 was provided:	1	(7	(7	
2 11 2	Month	Day	Year	
2. Name of medical practice or facility at v				
Capital Care No	Huscile Tule	do	er trek i direktira yang be	
3. Address of medical practice or faci	lity at which RU-486 v	vas provided:		
1160 NJ Sylvenia	Totals OH	43612		• * * * * * * * * * * * * * * * * * * *
4. Date post RU-486 complication be	gan: 12/19/17			
5. Event(s) (Please check all that appl	y):			
$\sqrt{.}$	dverse reaction to RU-486	Patient hospitalized	1	
Patient received a transfusion Severe bi	eeding			
Other serious event (specify)				
6. Duration of event: Hours	3 Days			
7. Remarks:				
7. Remarks: D2(, on 12)	22/17 no f	irther con	mplications	
	,			
8. a. Name of physician who provided	RU-486 11. And	Nunni		
	11 4/1 17	<i>t</i>		
8. b. Physician's signature	Date 2 2	4/17	(M.D)D.O	
end completed forms to:	State Medical E	Board of Ohio		
Le	egal Department			

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

JAN 1 7 2018

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		28	2017	
	Month	Day	Year	
2. Name of medical practice or facility at which	RU-486 was prov	rided:		
Capital Care 1	letwork	Toledo		
3. Address of medical practice or facility a	it which RU-486	was provided:		
1160 W Sylvan	sie Ave -	Toledo, of	43612	
4. Date post RU-486 complication began:	1/6/18			
5. Event(s) (Please check all that apply):				
	e reaction to RU-486	Patient hospita	lized	
Patient received a transfusion Severe bleedin	g			
Other serious event (specify)				
C. Duration of quant	Davia			
6. Duration of event: Hours				
7 Remarks:		. 1	8	
7. Remarks: DEC ON 1/6/1	s No to	THUER COM	application	
8. a. Name of physician who provided RJJ-	186 1. /	N N	. ()	
o. a. Name of physician who provided no	7) 71	fun Nann	1111	
8. b. Physician's signature	N-1/T	elly	M.D/JD.O	
	Date 11911	.q /		

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

JAN 2 2 2018