

(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provi	ded:	01_	<u> </u>		2017
		Month	Day	•	Year
2. Name of medical pract Planned Parel	ice or facility at which RU-4 NHNOOD East	486 was pr SUM	ovided:		
3. Address of medical prac	ctice or facility at which RU	406			
3255 East M	ain St., Colur	1110US,	Chic 4	13213	3
4. Date post RU-486 comp	lication began: 1/23	17			
5. Event(s) (Please check a	ll that apply):	· · · · · · · · · · · · · · · · · · ·		· · · · · · · · · · · · · · · · · · ·	
X Incomplete abortion	Adverse reacti	ion to RU-48	6 Patient hos	pitalized	
Patient received a transfusi	on Severe bleeding				
Other serious event (specify	1)				_
6. Duration of event:	Hours   Da	ays			
7. Remarks:					
DtC after Inc	complete Med	ticati	on Abou	tion	
8. a. Name of physician wh	o provided RU-486	Cather	ine Ron	annas	)
8. b. Physician's signature		· (		10/10/2	
	Date —			4D/DO 750/1-7	)
Send completed forms to:	State Medical Boa	ard of Ohio	)		
	Legal Department				
	30 E. Broad St., 3 <sup>rd</sup> Floor		MEDICAL	SOARD	·
•	Columbus, OH 43215-61	.27	EER 0.1		



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

#### State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provid	
	Month Day Year
2. Name of medical practice Planned Parén	e or facility at which RU-486 was provided: HNCOCLEUST SUNGIA
3 Address of medical practi	ce or facility at which RU-486 was provided:
	ain St., Columbus, Chio 43213
4. Date post RU-486 compli	cation began: $01/24/17$
5. Event(s) (Please check all	that apply):
Incomplete abortion	Adverse reaction to RU-486 Patient hospitalized
Patient received a transfusion	nSevere bleeding
Other serious event (specify)	Failed Medication Abortion
6. Duration of event:	HoursDays
7. Remarks: D+C af	ter failed medication abortion
8. a. Name of physician who	provided RU-486: Catherine Romanos
8. b. Physician's signature	MA (DO
,	Date
Send completed forms to:	State Medical Board of Ohio
	Legal Department
	30 E. Broad St., 3 <sup>rd</sup> Floor
	Columbus, OH 43215-6127 MFO(CA) BOART
Prescribed: 5//2011 Page 12/12/12	FEB 01 2017



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provid	ed:		19	2017
	विचार	Month	Day	<u> </u>
2. Name of medical practic Planned Part	e or facility at which I	RU-486 was provi UST - SUV	ded: Jical	
3. Address of medical practi 3255 East M	- · · · · · · · · · · · · · · · · · · ·			13
4. Date post RU-486 compli	cation began:	30/17		
5. Event(s) (Please check all	that apply):	•		
Incomplete abortion	Adverse r	reaction to RU-486	Patient hospitalize	d
Patient received a transfusion	n Severe bleeding			
Other serious event (specify)				
6. Duration of event:	Hours	_ Days		
7. Remarks: Incomplete MA	B Réquirin	9 050	·	
8. a. Name of physician who	provided RU-486	Cattrevir	re Roman	îs
8. b. Physician's signature	Date		9 19 VI	no
Send completed forms to:		al Board of Ohio	<i></i>	
, == , = ,	Legal Department	ar board or Onio	•	
•	30 E. Broad St., 3 <sup>rd</sup> F	loor		
	Columbus, OH 4321	15-6127	MERCICAL	SCIARD
			FEB 2	2 2017



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	$\mathcal{Q}$		((	2017
	Month		Day	Year
2. Name of medical practice or facility at w Plunned Purentheed -	thich RU-486 was East SUK	provided:		
3. Address of medical practice or facility at	which RU-486 wa	ıs provided:		
3255 East Main St., (			. 4321	3
4. Date post RU-486 complication began:	2/14/17			
5. Event(s) (Please check all that apply):				
Incomplete abortion Ad-	verse reaction to RU	-486 Pa	tient hospitalized	
Patient received a transfusion Severe blee	ding			
X Other serious event (specify) Failed	Medicatio	n Ab	outien	
6. Duration of event: Hours	<u>Days</u>			
7. Remarks: Failed Medication	en Abort	ion -	·	
8. a. Name of physician who provided RU-4.	86 _		ROMCUR	
8. b. Physician's signature		2	MD./I	
	Date		2/21/1	7
Send completed forms to: State N	Nedical Board of (	Ohio		
Legal Departm			MTDII AL S	30ARD
30 E. Broad St.	, 3 <sup>rd</sup> Floor			
Columbus, OH	43215-6127		FEB 22	2017



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provi	ded:	2	23	HAN ARREST
		Month	Day	Year
2. Name of medical practi	ce or facility at which RU-4 Pare thood	86 was provid	ed:	
3. Address of medical prac	tice or facility at which RU-			
4. Date post RU-486 comp	lication began:			
5. Event(s) (Please check a	ll that apply):			
Incomplete abortion	Adverse reacti	on to RU-486	Patient hospitalized	
Patient received a transfusion	on Severe bleeding			
Other serious event (specify	)			
6. Duration of event:	Hours Da	ys		
7. Remarks: Merk A	Bincomplete	Miso	repeat dus	ing.
8. a. Name of physician wh	o provided RU-486	Zomano	<u>)</u>	
8. b. Physician's signature	Date —		MD/D 3/7/	o
send completed forms to:	State Medical Bo Legal Department	ard of Ohio		
	30 E. Broad St., 3 <sup>rd</sup> Floor Columbus, OH 43215-61	.27	MEDICAL BO	ADD
		<del></del>	MAR 1 7 2017	



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		63	30	2017
		Month	Day	Year
2. Name of medical practice or	facility at which I	RU-486 was prov	ided:	
Manned Pareni				
3. Address of medical practice o	r facility at which ないう られ(	RU-486 was pro	vided: 1/37	1.(3
4. Date post RU-486 complicatio	n began: 니/	3/17		
5. Event(s) (Please check all that	apply):			
Incomplete abortion	Adverse r	eaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion	_Severe bleeding			
Other serious event (specify)				· · · · · · · · · · · · · · · · · · ·
6. Duration of event:	Hours 5	_ Days		
7. Remarks: Dic perfund	, uncu	mpV cake	<i>A</i> .	
8. a. Name of physician who prov	vided RU-486	Catherin	a formani	S
8. b. Physician's signature _	Date		S WY	1417
Send completed forms to:	State Medica	l Board of Ohio	-	
Leg	al Department			
30 I	. Broad St., 3 <sup>rd</sup> F	loor	n amount ( phys A !	BOARD
Coli	umbus, OH 4321	5-6127		
			ADR (	7 2017



(Required pursuant to R.C. 2919.123)

			•
1. Date RU-486 was provided:	A. Dril	24	2017
	Month	Day	- 101 / Voor
2. Name of medical practice or facility at which RU- Planned Parenthood Eust	-486 was provid		Year
3. Address of medical practice or facility at which RU	· ·	.*	
3255 E. Main St. Columb		1	A PERSONAL PROPERTY CONTRACTOR CO
4. Date post RU-486 complication began: 5 / 1 / 7	•		
5. Event(s) (Please check all that apply):		•	MEDICA
Incomplete abortion Adverse read	ction to RU-486	Patient hospitalized	MAY 1 2 20
Patient received a transfusion Severe bleeding			5 STORY
Other serious event (specify)			
6. Duration of event: N A Hours	Days	1	
7. Remarks: Troomplete MAB, Dd	c perfor	med 5/9/17	
			·
8. a. Name of physician who provided RU-486	Komo	inos	
8. b. Physician's signature		Ma Dag	
Date —		51	9/7
Send completed forms to: State Medical E	Board of Ohio		
Legal Department		AMED	ICAL BOAF
30 E. Broad St., 3 <sup>rd</sup> Floo	or	A I Sem ye.	
Columbus, OH 43215-	6127	1	<sub>vi</sub> , <b>2, 201</b> 7
Prescribed: 5//2011, Rev. 12/13/12		, · ·	



(Required pursuant to R.C. 2919.123)

				•
1. Date RU-486 was provid	led:	Tune		2 (2) 2
		Month	Day	2017
2. Name of medical practic	ce or facility at which	RU-486 was provid	,	Year
E,	3St Sumir	Ctr Dia	1 00 -	<b>( ( ( ( ( ( ( ( ( (</b>
	ast Surger	901. ra	rmed fure	nthoad
3. Address of medical pract	ice or facility at which			
1 5255 E. Mai	hst.			
C	olumbus,	OH 43217		
4. Date post RU-486 compl				
		19117	1 a a a a a a a a a a a a a a a a a a a	
5. Event(s) (Please check al		1,11		
	renac apply);			
Incomplete abortion	Adverse	reaction to RU-486	Patient hospitalize	ď
				- -
Patient received a transfusion	n Severe bleeding			
1	. 1			
Other serious event (specify	Lema	tometra		
(opeany		TOTELL		
6. Duration of event:	Hours	Days		
7 Remarks: O				
7. Remarks: Patient	had aspi	ration on	0 9/17	
-	ſ			
Q a Name of physician I		7/00/D 01	1 00	
8. a. Name of physician who	provided RU-486	Cuthen	he Roman	nas
8. b. Physician's signature			( ND	<u> </u>
	Dat	te	11417	
Send completed forms to:				
sens completed forms to:		cal Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 <sup>rd</sup>		MEDICAL BOY	A Section of
	Columbus, OH 432	215-6127		
			JUN 1 9 2017	
Prescribed: 5//2011, Rev. 12/13/12				



(Required pursuant to R.C. 2919.123)

4 5 1 211 4 2			•
1. Date RU-486 was provided:	June	7	2017
	Month	Day	Year
2. Name of medical practice or facility at which RU Planned Paventhoed	-486 was provid East	led:	real
3. Address of medical practice or facility at which R	U-486 was prov	ided:	
2055 6 1		SOH L	13213
4. Date post RU-486 complication began:  (0 21 17 4+	•	ollow uf	`` <del>`</del>
fuled		<b>[</b>	
Adverse read	ction to RU-486	Patient hospitali	zed .
Patient received a transfusion Severe bleeding			
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks: Surgical AB after	nedical	AB on	6/22/17
	Ca	herine	
8. a. Name of physician who provided RU-486	Long	anos	
8. b. Physician's signature		Mo	400
Date -		6/27/1	
Send completed forms to: State Medical	Board of Ohio		
Legal Department			
30 E. Broad St., 3 <sup>rd</sup> Flo	or		
Columbus, OH 43215-			
•		MEDICAL 8	JOARD
Prescribed: 5//2011, Rev. 12/13/12			
		JUN 28;	2017



(Required pursuant to R.C. 2919,123)

To be completed by the physician who provided RU-486

			1 12	•
1. Date RU-486 was provid	led:	June	26002	017
		Month	Day	Year
2. Name of medical practic	ce or facility at which RU Linent hood Ed	J-486 was provid ASH	led:	i Gai
3. Address of medical pract	tice or facility at which F	RU-486 was prov	ided:	
			lueu.	
3255 E. Mair	18t. Colur	nbus of	43213	
4. Date post RU-486 compl	ication began: Tune 26	•		
5. Event(s) (Please check al	I that apply):			
Incomplete abortion		ection to RU-486	Patient hospitalized	
Patient received a transfusion	on Severe bleeding			
Other serious event (specify	)			<del></del>
6. Duration of event:	Hours	Days		
7. Remarks:				
le/2le-8urg	ical AB after	rinum	plate Mcd	AB
8. a. Name of physician wh		[ all a	· 10 -	•
8. a. Name of physician who	o provided RU-486	Lumann	e Kananes	
8. b. Physician's signature		1		
			(000/00	_ 0
,	Date -		0/20/17	er
Send completed forms to:	State Medical	Board of Obje	. 1.	27/7
	Legal Department		4/0	7 / /
	30 E. Broad St., 3 <sup>rd</sup> Flo	or		
	Columbus, OH 43215	į.	MEDICAL BO	ARD
Prescribed: 5//2011 Pay 12/12/12			JUN 2 8 201	7

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(Required pursuant to R.C. 2919.123)

				•
1. Date RU-486 was provi	ded:		23	17
		Month	Day	Year
2. Name of medical practi East P	ce or facility at which	h RU-486 was provid CntL&d	ded:	tear
3. Address of medical prac	tice or facility at whi	ch RU-486 was prov	ided:	
3255 B.M	arh St.	Columbu	S,0H 433	213
4. Date post RU-486 comp	lication began:	7117		
5. Event(s) (Please check a	ll that apply):			
Incomplete abortion	Advers	e reaction to RU-486	Patient hospitaliz	ed • • • • • • • • • • • • • • • • • • •
Patient received a transfusi	on Severe bleeding			
Other serious event (specifi	, failed	MAB		
6. Duration of event:	Hours	Days		
7. Remarks	n 7/3/17 a	t MAB Bil	ow up app	h <sub>3</sub>
8. a. Name of physician wh	o provided RU-486	Cath	enne Dov	MIO S
8. b. Physician's signature			MD	7010/83
	Da	te	7	5/17
Send completed forms to:	State Med	ical Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 <sup>rd</sup>			
	Columbus, OH 43	215-6127	MED	ICAL BOARD
Prescribed S. J. John			J	UL 1 0 2017



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	7,		·
-	July	<u> </u>	2017
2 Name of modical prosting of the	Month C	Day	Year
2. Name of medical practice or facility at which RU Pland Parenthad East	-486 was provid	ed:	
3. Address of medical practice or facility at which R	11-486 was prov		
2255 C 1.			
1 Ce	, lumbus,	OH 43213	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
	ction 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	Cathor	the longras	
8. b. Physician's signature		ND /AO	
Date -		10000	
Cond	3	$\rightarrow$ . $+$	
	oard of Ohio   		
Legal Department 30 E. Broad St., 3 <sup>rd</sup> Flo		MEDION PORR	<b>5</b>
Columbus, OH 43215-	4	\$ WEEK 1	
	017/	JUL 6 3 KNIV	
Prescribed: 5//2011, Rev. 12/13/12			
,, <del></del>		£-	



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provid	ed:	8	16	17
·	•	Month	Day	Year
2. Name of medical practic	e or facility at which RL University	1-486 was prov	ided:	real
3. Address of medical practi	ice or facility at which F	U-486 was pro	vided:	
3255 6 Ma	in St. Col	umbus,	OH 432	13
4. Date post RU-486 compli	cation began:	•		
5. Event(s) (Please check all	that apply):			
Incomplete abortion	Adverse rea	ction to RU-486	Patient hospita	ilized
Patient received a transfusion	n Severe bleeding		:	
Other serious event (specify)	Fouled 1	NAB		
6. Duration of event:	Hours	Days		
7. Remarks: Diation of	und suction-	unampli.	atd.	
8. a. Name of physician who	provided RU-486	cart	wer he	Komanos
8. b. Physician's signature			M	
, g	Date -	8)	20/17	3-7-0-0
Send completed forms to:	State Medical	Board of Ohio	1	
	Legal Department			
	30 E. Broad St., 3 <sup>rd</sup> Flo	or	META	No. 2008.1
	Columbus, OH 43215			16 2 4 701 <sup>5</sup>



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1 5 1 511 100				•
1. Date RU-486 was provided:	_	8	28	17
		Month	Day	Year
2. Name of medical practice or facili	ty at which RU and East	-486 was providence Surger	ded:	
3. Address of medical practice or faci	lity at which PI	1-196 1125 250	11-1	
í			1	
3255 E. Main St.	Colum	bus, OH	43213	
3255 E. Main St. 4. Date post RU-486 complication be	gan: 9   -	7/17		
5. Event(s) (Please check all that appl	y):			
Incomplete abortion	Adverse read	tion to RU-486	Patient hospitalize	ed .
Patient received a transfusion Seve	ere bleeding			
Other serious event (specify)				
6. Duration of event: Hou	ırs[	Days		
7. Remarks:				
uncomplicate	d such	an proced	lice.	
8. a. Name of physician who provided	L DIL ADC	Calla	· · · · · · · · · · · · · · · · · · ·	
	1 10-486	Catae	The Rom	anas
8. b. Physician's signature		<i></i>	S Sup	<del>p.o</del>
	Date —		9/21	19
Send completed forms to:	tate Medical B	oard of Ohio		//
Legal De	partment			
	oad St., 3 <sup>rd</sup> Floo	ır	a	31085 365
	us, OH 43215-6	i	i we	DICAL BOARD
		· · · · · <del>· ·</del>		SEP & & Col.

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

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(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:			•
- Just No 480 was provided:	_ 01	/ 8	17
2. Name of modical practice or (a till	Month	Day	Year
2. Name of medical practice or facility at which R	U-486 was provid	led:	
Planned Parentheod East	Surgery		
3. Address of medical practice or facility at which	RU-486 was prov	ided:	
3255 E. Main St. Colum	bus (214	43213	
4. Date post RU-486 complication began: 9/22/17		(343	
5. Event(s) (Please check all that apply):			
incomplete abortion Adverse re	action to RU-486	Patient hospitalized	en e
Patient received a transfusion Severe bleeding	:		
Cother serious event (specify)Falled	Medication	abortion	
6. Duration of event: Hours	Days		
7. Remarks:			
uncamplicated s	uction		
8. a. Name of physician who provided RU-486	Cuff	enne Pa	manos
8. b. Physician's signature		< 0.00	
Date		0/25	
Sand	Board of Ohio	7103	/
Legal Department	board of Office		
30 E. Broad St., 3 <sup>rd</sup> Flo	oor		
Columbus, OH 43215 MEDICAL BOARD  Prescribed: 5/- Stopp. 2013/1/2			
Prescribed: 5/-960 3eg 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:	9	21	•
	Month	Day	<u> </u>
2. Name of medical practice or facility at which F Flurned Parenthood	RU-486 was provid		Year
3. Address of medical practice or facility at which	RU-486 was prov	idadı	
3755 E Maih St. Col	umbus,	PH 432	13
4. Date post RU-486 complication began:	•		
5. Event(s) (Please check all that apply):			
Kincomplete abortion Adverse re	eaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe bleeding			
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:	7		
8. a. Name of physician who provided RU-486	Caff	entre Rom	1 (
8. b. Physician's signature		)	Anos
Date		5 9/27	9.0 //
Send completed forms to: State Medica	l Board of Ohio		
Legal Department			
30 E. Broad St., 3 <sup>rd</sup> Fl	1		
Columbus, OH 4321	5-6127	WEI	DICAL BOARD
Prescribed: 5//2011, Rev. 12/13/12			SEP 2 8 2017

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(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:		
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	25	2017
2 Name of modified	Day	Year
2. Name of medical practice or facility at which RU-486 was provide Planned Parenthood East Surgery	ed:	
3. Address of medical practice or facility at which RU-486 was prov		
3255 E Main St. Columbus, OH	43215	
4. Date post RU-486 complication began:		
5. Event(s) (Please check all that apply):		
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: Levelace Dic.		
!		
a. Name of physician who provided RU-486	onne Pa	
b. b. Physician's signature	0.72	nanos
	(MD)/C	2.0
Date	2 10/1/10/	( )
end completed forms to:  State Medical Board of Ohio  Legal Department		MEDICAL BOAR
30 E. Broad St., 3 <sup>rd</sup> Floor		OCT 2 3 2017
		2 o ZUI/
Columbus, OH 43215-6127		
rescribed: 5//2011, Rev. 12/13/12		



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

4 5 . 511.45				
1. Date RU-486 was provided	d:	OC+.	9	2017
		Month	Day	Year
2. Name of medical practice Planned far	or facility at which ferthood [-	RU-486 was provided of Surg	led:	
3. Address of medical practic	e or facility at which	RU-486 was prov	ided:	
3255 E Mail				
4. Date post RU-486 complication	ation began:			
5. Event(s) (Please check all t	hat apply):			
Incomplete abortion	Adverse r	eaction to RU-486	Patient hospitalized	d
Patient received a transfusion	Severe bleeding			
Other serious event (specify)	failed	MEB		
6. Duration of event:	Hours	_ Days		
7. Remarks:				
8. a. Name of physician who p	provided RU-486	Cathe	erihe form	lanos
8. b. Physician's signature		A. A. Carrier	(AD)	D.O
	Date		10/1	u/17
Send completed forms to:	State Medic	al Board of Ohio		
	Legal Department	a. Dould of Offio		
	30 E. Broad St., 3 <sup>rd</sup> F	Floor		
	Columbus, OH 4321		AVEL	ICAL BOARD
	,			
Prescribed: 5//2011, Rev. 12/13/12				OCT 1 8 2017

**%** 



#### State Medical Board of Ohio Report of RU-486 Event MEDICAL BOARD

To be completed by the physician who provided RU-486

NOV 0 3 2017

1 Date Division			,
1. Date RU-486 was provided:	10		11
	Month .	Day	
2. Name of medical practice or facility at which RL	J-486 was provi	ded:	Year
lanned paventhood	[ac	Swaen	
3. Address of medical practice or facility at which R	U-486 was prov	ided:	
Columbus OH 43213			
			į.
4. Date post RU-486 complication began:			
[0 31/1	7		
5. Event(s) (Please check all that apply):			
M	•		
Incomplete abortion Adverse rea	ction to RU-486	Patient hospitalized	
			-
Patient received a transfusion Severe bleeding			
Other serious event (specify)		·	
6. Duration of event: Hours			
Hours	Days		
7. Remarks:			
Lanca oire for			
uncomplicated	7.5		
;			
8. a. Name of physician who provided RU-486	Catho	· / //	•
8. b. Physician's signature	Calvie	The Romai	205
or all rivisician's signature		(MB/D	0
Date _		10/3/17	
Send completed forms to: State Medical E	loard -f Cir	1.	
Legal Department	old of Oblo		
30 E. Broad St., 3 <sup>rd</sup> Floo			
Columbus, OH 43215-	6127		
Prescribed: 5//2011, Rev. 12/13/12		•	
	1		



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:			•
provided.	UC+	16	2017
2 14	Month	Day	Year
2. Name of medical practice or facility at which R	U-486 was provid	ed:	
Planned parenthood East	Cursim (	Center	
	1		
3. Address of medis 255 et 196 air es ity at which	RU-486 was prov	ided:	
Columbus OH 43213			
			,
4. Date post RU-486 complication began:			
11 21	(7		
5. Event(s) (Please check all that apply):			
	•		
Adverse re	action to RU-486	Patient hospitalized	
Patient received a transfer to			•
Patient received a transfusion Severe bleeding			
Other serious event (specify)			1
6. Duration of event: Hours	Dave		
	_ Duy3		
7. Remarks:			
uncomplicated i	1.0		
		•	
8. a. Name of physician who provided RU-486	Cath	ente bou	nanos
8. b. Physician's signature		For	WALLIEST
		MD/	<u> </u>
Date		11/2	8/1)
Send completed forms to: State Medical	Board of Ohio		
Legal Department			
30 E. Broad St., 3 <sup>rd</sup> Flo	oor		
Columbus, OH 43215	i		_
, - 10 1021		WE	DICAL BUARIT
Prescribed: 5//2011, Rev. 12/13/12			NOV 3 0 2017
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(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	Dal		
l la	Month	[8]	2017
2. Name of medical practice or facility at which I	500000	Day	Year
Planned Panenthood	10-486 was provid	ed:	
	17		
3. Address of medical practice or facility at which	RU-486 was provi	ded:	
3.55 E. Main St. Co  4. Date post RU-486 complication began:	lumbus o	4 4321	<b>)</b>
4. Date post RU-486 complication began:	117		
5. Event(s) (Please check all that apply):			
Name of the state			
Adverse r	eaction to RU-486	Patient hospitalize	ed .
Patient received a transfusion Severe bleeding			
Other serious event (specify)			
6. Duration of event: Hours	_ Days		
7. Remarks:			
unramplica keci	Dic		
8. a. Name of physician who provided RU-486	Cathoda	in Rom	anas
8. b. Physician's signature			4110)
		S (MD)	100
Sand complete I.C.		12	[25 [1]
	I Board of Ohio		
Legal Department			
30 E. Broad St., 3 <sup>rd</sup> F	i i		
Columbus, OH 4321	5-6127	M	EDICA BOARD
Prescribed: 5//2011, Rev. 12/13/12			OCT 3 0 2017



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1 Date DIL 400					
1. Date RU-486 was provid	ed:	ID	(8	17	
		Month	Day		
	aventhood ta	St Surg	ed: erty	Year	
	ice or facility at which RU 255 E. Main St. Columbus OH 43213	J-486 was prov	ided:		
	25/17	•			
5. Event(s) (Please check al	that apply):				
Macomplete abortion	Adverse reac	tion to RU-486	Patient hospital	ized	
Patient received a transfusio	nSevere bleeding	,			ACCOME A PROPERTY OF A PARTY OF A
Other serious event (specify					The state of the s
6. Duration of event:	Hours D	ays			
7. Remarks:					
	braka DiC				
8. a. Name of physician with		001	).		
8. a. Name of physician who 8. b. Physician's signature	provided RU-486	Cage	erine	Romano	5
	Date		) 11/2	100	
Send completed forms to:	State Medical B	pard of Ohio			
·.	Legal Department	OI OIIIO			
	30 E. Broad St., 3 <sup>rd</sup> Floo	<b>,</b>		. <b></b>	
	Columbus, OH 43215-6		MEDI	CAL BOARD	
		175/	N	OV 0 6 2017	



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provid	ded:	Mari		
		Month	9	2017
2. Name of medical practi	ce or facility at which PL		Day	Year
Planned	Parentlood	400 was provid	led:	
			Surgery	
3. Address of medical prac	ice of acility at which F	RU-486 was prov	ided:	
Columbus	OH 43213			
A Data past DI Ans				•
4. Date post RU-486 compl	ication began:			
5. Event/s) /Please chall al	71/7			
5. Event(s) (Please check al	i that apply):			
Incomplete abortion	Adverse rea	ection to RU-486	Patient hospitalize	4
<b>D</b>				· •
Patient received a transfusion	on Severe bleeding			
1	<del>-</del> <,			ACTOR A SACON
Other serious event (specify	- taile	ed MXB		and the second s
6. Duration of event:	Hours	Days		
7. Remarks:				
Le mar millan	d d o bee			
3 Senciamper co	ited suctive			
3				
8. a. Name of physician wh	provided RU-486	Catha	inhe for	nanos
8. b. Physician's signature		d	101	- was US
	D-1		- MD/	0.0
Send completed forms to:	Date -		1/2://	7
seria completed forms to:	State Medical	Board of Ohio		
,	Legal Department			
•	30 E. Broad St., 3 <sup>rd</sup> Flo		MEDIC	DAL BOARD
	Columbus, OH 43215-	-6127	•	
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(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provide	ed:			
		Month	120	17
2. Name of medical practice	or facility at wh	WOILII	Day	Year
Diamed Car	- Of facility at Wh	cn RU-486 was prov	/ided:	
Planned Pan	mhied	sast Slargen	y Ctv.	
3. Address of medical practi	ce or facility at			
3255 E. N	lain Si	nich KU-486 was pro	ovided:	
Columbus	OH 43213			
4. Date post RU-486 complic	otton h			
	ation began:			
5. Event(s) (Places short "		1/30/17		
5. Event(s) (Please check all	that apply):			
Incomplete abortion	Adva	rse reaction to RU-486		
		ise reaction to RU-486	Patient hospitalize	ıd .
Patient received a transfusion	Severe bleedir			
		<b>15</b> 		
Other serious event (specify)	fre 1	ad 1110	•	
		LU TUAS		
6. Duration of event:	Hours	Days		
7. Remarks:				
	a)	7		
uncamy	Du cated	0.5		
3				
a. Name of physician wha			•	
3. a. Name of physician who	provided RU-486	- Cert	tenne Rov	nanos
. b. Physician's signature				
	r	Date	M.D./	<u> </u>
end completed forms to:				
	State Me	dical Board of Ohio		
•.	Legal Departmen			Million & Some
	30 E. Broad St., 3			DEC 18 2017
	Columbus, OH 4	3215-6127		DEC 18 con
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