State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 10 (Month) 31 (Day) 19 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
THE Founder's Women's Health Ctr.

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St. Col's, OH 43205

4. Date post RU-486 complication began: 11-1-19

5. Event(s) (Please check all that apply):

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) Failed abortion

6. Duration of event: _____ Hours 14 Days

7. Remarks: Patient took misoprostol incorrectly and failed the abortion. She was sent to Women's Med Center in Dayton, Ohio for a D&C.

8. a. Name of physician who provided RU-486 Karl Schaeffer

8. b. Physician's signature Karl Schaeffer (M.D./D.O.)

Date 11-14-19

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

MEDICAL BOARD
NOV 18 2019

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

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: 10 (Month) 22 (Day) 19 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
The founder's Women's Health Center

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St Col's, OH 43205

4. Date post RU-486 complication began:
11-6-19

5. Event(s) (Please check all that apply):

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) Failed abortion

6. Duration of event: ____ Hours 14 Days

7. Remarks:
Patient sent for D+C on 11/12/19 to Women's Med Center in Dayton, Ohio.

8. a. Name of physician who provided RU-486 Karl Schaeffer, MD

8. b. Physician's signature Karl Schaeffer M.D/D.O

Date 11-7-19

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 09 (Month) 19 (Day) 2019 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
The founder's Women's Health Center

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St. Columbus, OH 43205

4. Date post RU-486 complication began: 10/02/19

5. Event(s) (Please check all that apply):

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) Failed abortion

6. Duration of event: _____ Hours 14 Days

7. Remarks:
Patient had failed abortion and was sent to The Women's Health Center in Dayton, Ohio for surgical abortion.

8. a. Name of physician who provided RU-486 Karl Schaeffer, MD

8. b. Physician's signature Karl Schaeffer MD/DO

Date 10-2-19

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

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 9 (Month) 19 (Day) 19

2. Name of medical practice or facility at which RU-486 was provided:
The founder's Women's Health Ctr.

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St. Columbus, OH 43205

4. Date post RU-486 complication began:

5. Event(s) (Please check all that apply):

✓ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: _____ Hours 14 Days

7. Remarks:
Patient has incomplete abortion and is referred to the Women's Medical Center in Dayton for surgical abortion.

8. a. Name of physician who provided RU-486 Karl I. Schaeffer

8. b. Physician's signature Karl I. Schaeffer MD

Date 10-3-19

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

MEDICAL BOARD
OCT 04 2019

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

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: 9 (Month) 12 (Day) 2019 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
The founder's Women's Health Center

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad Street
Columbus, OH 43205

4. Date post RU-486 complication began:
9-24-19 is when clinic was consulted

5. Event(s) (Please check all that apply):

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) Failed abortion

6. Duration of event: ____ Hours 12 Days

7. Remarks:
Patient had failed abortion Discussed with patient need for surgical abortion. Patient left clinic without arrangements.

8. a. Name of physician who provided RU-486 Karl F. Schaeffer, MD

8. b. Physician's signature Karl D. Schaeffer (M.D./D.O.)

Date 9-25-19

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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: 6 (Month) 25 (Day) 2019 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
The Founders Women's Health Center

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad Street
Columbus, Ohio 43205

4. Date post RU-486 complication began:
7-9-19

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 14 Days

7. Remarks:
Patient sent to Women's Med Center in Dayton, Ohio for a D+C. for retained tissue in the uterus.

8. a. Name of physician who provided RU-486 Karl I. Schaeffer, MD

8. b. Physician's signature Karl D. Schaeffer M.D/D.O

Date 7-10-19

Send completed forms to:

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

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) 22 (Day) 19 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
The founder's Women's Health Ctr.

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St
Columbus, OH 43205

4. Date post RU-486 complication began:
6-6-19

5. Event(s) (Please check all that apply):

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) Failed RU-486

6. Duration of event: _____ Hours 16 Days

7. Remarks: Patient had failure of medical abortion and was sent to Women's Medical Center in Dayton, Ohio for a D+C.

8. a. Name of physician who provided RU-486 Karl I. Schaeffer, MD

8. b. Physician's signature Karl D. Schaeffer (M.D/D.O)

Date 6-17-19

Send completed forms to:

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

MEDICAL BOARD
JUN 19 2019

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: 4 (Month) 16 (Day) 19 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Founder's Women's Health Center

3. Address of medical practice or facility at which RU-486 was provided:
1243 East Broad Street
Columbus, Ohio 43205

4. Date post RU-486 complication began:
5-2-19

5. Event(s) (Please check all that apply):

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) Failed Mifeprex / Misoprostol abortion

6. Duration of event: ____ Hours 14 Days

7. Remarks:
Patient sent to Women's Medical Center in Dayton, Ohio on 5/3/19 for surgical abortion

8. a. Name of physician who provided RU-486 Karl I. Schaeffer, MD

8. b. Physician's signature Karl I. Schaeffer (M.D./D.O.)

Date 5-2-19

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

MAY 08 2019

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: 2 (Month) 12 (Day) 2019 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
The Founder's Women's Health Center.

3. Address of medical practice or facility at which RU-486 was provided:
1243 East Broad Street
Columbus, Ohio 43205

4. Date post RU-486 complication began:
2-18-19

5. Event(s) (Please check all that apply):

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) Failed Mifepryx

6. Duration of event: ____ Hours 6 Days

7. Remarks: Patient sent to Women's Med Center in Dayton, Ohio for surgical abortion

8. a. Name of physician who provided RU-486 Karl I Schaeffer, MD

8. b. Physician's signature Karl I. Schaeffer (M.D)/D.O

Date 2-19-19

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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) 24 (Day) 2019 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Founder's Women's Health Center

3. Address of medical practice or facility at which RU-486 was provided:
1243 E Broad Street
Columbus, Ohio 43205

4. Date post RU-486 complication began:
2-5-19

5. Event(s) (Please check all that apply):

✓ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: ____ Hours 14 Days

7. Remarks:
Patient has retained tissue and was sent to Women's Med Center in Dayton, Ohio for surgical procedure.

8. a. Name of physician who provided RU-486 Karl F. Schaeffer, MD

8. b. Physician's signature Karl D. Schaeffer (M.D/D.O)

Date 2-14-19

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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) 17 (Day) 19 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
The founder's Women's Health Ctr.

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St. Columbus, OH 43205

4. Date post RU-486 complication began:

5. Event(s) (Please check all that apply):

X Incomplete abortion fetal demise ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: _____ Hours 14 Days

7. Remarks: Patient had a Fetal Demise & retained products in the uterus. Patient was sent to Women's Med Center in Dayton, Ohio for a surgical abortion.

8. a. Name of physician who provided RU-486 Karl J. Schaeffer, MD

8. b. Physician's signature Karl J. Schaeffer M.D/D.O

Date 1-31-19

Send completed forms to:

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

MEDICAL BOARD
FEB 04 2019

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: JAN. (Month) 03 (Day) 2019 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Founder's Women's Health Ctr.

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St.

4. Date post RU-486 complication began:
JAN. 4th or 5th 2019

5. Event(s) (Please check all that apply):

X Incomplete abortion (Medical) ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: ____ Hours 13 Days

7. Remarks: fetal demise - pt. referred to The Women's Med Ctr. in Dayton, OH for D+C - appt. on 1-21-19

8. a. Name of physician who provided RU-486 Karl Schaefer, MD

8. b. Physician's signature Karl Schaefer (M.D./D.O.)

Date 1-17-19

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127