(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	10	31	19
	Month	Day	Year
2. Name of medical practice or facility at which F THE FOUNDER'S WOMEN'S Heat		rided:	78 to 1 to
3. Address of medical practice or facility at which 1243 E. Blood St. Cel's, CH. U		ovided:	
4. Date post RU-486 complication began:	1-19		
5. Event(s) (Please check all that apply):			
Incomplete abortion Adverse re	eaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe bleeding			
Other serious event (specify) Failed	abortrog		
6. Duration of event: Hours	Days		
7. Remarks: Patreul took wiso failed the abortion	prostal	in correctly	and
8. a. Name of physician who provided RU-486	ou Ohio	for a Dir	C.
8. a. Name of physician who provided RU-486	- Karl	Schaeffer	-
	11-14-19	7	0.0
Send completed forms to: State Medical			

**Legal Department** 

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127

**MEDICAL BOARD** 

NOV 1 8 2019

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	10	20-	19	<del>(</del>
	Month	Day	Year	
2. Name of medical practice or facility at which R				
THE founder's Wornen's	Health	, Center		
3. Address of medical practice or facility at v	vhich RU-486 v	was provided:		
1243 E. Broad St. C				
4. Date post RU-486 complication began:	-6-19			
5. Event(s) (Please check all that apply):			CONTROL MANAGEMENT OF THE STATE	
Incomplete abortion Adverse re	action to RU-486	Patient hospitalized	d	
Patient received a transfusion Severe bleeding				
Other serious event (specify) Fall	ed abo	ortion		
6. Duration of event: Hours Da	nys			
7. Remarks:				
Patreut sent for	DtC	ou u/cz	119 to Wallen	
Wed Center in De	extour	Otro.	,	
8. a. Name of physician who provided RU-48	6 Kar	1 Schaef	fer und	
-	Schae	.0	(M.D/D.O	
	Date((	1-14		

Send completed forms to:

State Medical Board of Ohio

1.5

**Legal Department** 

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:		09	19	2019
		Month	Day	Year
2. Name of medical practice of The Founder's			ente	
3. Address of medical practice	or facility at which	RII-486 was provid	dad:	
1243 E. BroaDS				
4. Date post RU-486 complicat	ion began:	10/02/1	9	
5. Event(s) (Please check all the	at apply):			
Incomplete abortion	Adverse re	eaction to RU-486 _	Patient hospitalize	d
Patient received a transfusion	Severe bleeding			
Other serious event (specify)	Fac	led aborti	on	
6. Duration of event:	Hours <u></u>	_ Days		
7. Remarks:  Portread her d  To The Way  Solvented of  8. a. Name of physician who pr  8. b. Physician's signature	•			
8. a. Name of physician who pr	ovided RU-486	Karl-	schaett	er, ub
8. b. Physician's signature	Kail Schi	uffer	(D)	DO
	Date	(0)	_ ,	
Send completed forms to:	State Medica	l Board of Ohio		20
Le	egal Department			SOAK
3	D E. Broad St., 3 <sup>rd</sup> F	loor		~ V/ 20
C	olumbus, OH 4321	5-6127		MEDICAL BOARD

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provid	led:	9	19		(9)
		Month	Da,		
2. Name of medical practice of the founder				No to Transmission of the State	
3. Address of medical pract	ice or facility at whi	ch RU-486 was pro	ovided:		
1243 E. Broz				05	
4. Date post RU-486 compl	ication began:				
5. Event(s) (Please check al	that apply):				MAN
4 Incomplete abortion	Advers	e reaction to RU-486	Patient hosc :	d ter	
Patient received a transfusio	nSevere bleeding				
Other serious event (specify)					-
6. Duration of event:	Hours	Days			
7. Remarks: Potient U referred t	as weaup o The Would	lete abor sus Medica	ition and (Center i	c circ	
8. a. Name of physician who	provided RU-486	Karl-	I. Schae	ffe ; .	*****
8. b. Physician's signature	Karl b.	Schaeffer		<u>) </u>	
,	Da	te <u>10 - 3 -</u>	19		one the state of t
Send completed forms to:	State Medi	cal Board of Ohio			nan-
	Legal Department			-010	DAL BOARS
	30 E. Broad St., 3 <sup>rd</sup>	Floor		WEDI	CAL BOARD
	Columbus, OH 43:	215-6127		()	

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

1. Date RU-486 was provided:				
1. Date KO-400 was provided:	4	12:	2019	
	Month	Day	Year *	
2. Name of medical practice or facility at which				
The founder's Women's H	ealth Center			
	, , ,			
3. Address of medical practice or facility a	t which RU-486 v	vas provided:		
1243 E. Broad Street				
Columbus OH 43205				
4. Date post RU-486 complication began:			ir 1	
9-24-19 is wi	ion clin	ic was	couso ted	
5. Event(s) (Please check all that apply):				
Incomplete abortionAdvers	reaction to RU-486	Patient hospitalize	1	
·	,			
Patient received a transfusionSevere bleeding	3			
Other serious event (specify) Feel	d about	CONT		
Other serious event (specify)				•
6. Duration of event: Hours	Days	•		
7. Remarks: Poetreut had tailed	a batto	Duran	in with	
Patient had tailed	) certacion		100 000 000 000 000 000 000 000 000 000	_
Patient need for	nugueal	allatte	i represent text	t "
Chuc wiffout a	rociópila	ite.		
			coffee wh	
8. a. Name of physician who provided RU-		_	everter and	<del></del>
8. b. Physician's signature	le O. Seli	aeffer	(M.D/p.o	
	Date 9-			
	Date	25 - Q		
Cand required forms to				
Send completed forms to:	State Medical E	Board of Ohio		
Legal	Department			
30 E. I	Broad St., 3 <sup>rd</sup> Floo	r	alle.	NRD
Calum	bus, OH 43215-6	197	-DICAL BC	)M'\
Colum	10U2, OH 43413-6	)± <b>८</b>	MEDICAL BC	C/C
			SEP N I C	83 2

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

1. Date RU-486 was provided:	6	25	2019	
	Month	Day	Year	
2. Name of medical practice or facility at	which RU-486 was pṛo	vided:		
The Foundross	Womens	tteatth	Center	
3. Address of medical practice or fac	ility at which DII 496	· was provided.		
1243 E. Broa	d Storet	was provided:		
Columbus, Ohi				
4. Date post RU-486 complication be	gan:			
, ,	gan.			
7-9-19				
5. Event(s) (Please check all that appl	y):			
XIncomplete abortion	dverse reaction to RU-486	Patient hospitalize	ď	
Patient received a transfusion Severe b	leeding			
Other serious event (specify)			Parameter (State Control of the Cont	
6. Duration of event: Hours _	<u> 1                                   </u>			
7. Remarks:			-	
Patient sent	to Woo	news Mea	1 Center in	Day ton,
Ohio for a				• • •
8. a. Name of physician who provided	RU-486 Kar	I.T. Sch	arter, ul	)
8. b. Physician's signature		chae/fer		
	Date	0-19		
Send completed forms to:	State Medical	Board of Ohio		

**Legal Department** 

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	02	22	19
	Month	Day	Year
2. Name of medical practice or facility at which RU	-486 was provi	ded:	
The founder's Women's	Health	GR.	
3. Address of medical practice or facility at w	hich 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 abortionAdverse rea	ction to RU-486	Patient hospitalize	ed
Patient received a transfusion Severe bleeding			
_Other serious event (specify) _ Fac(ea	RU.	-486	
6. Duration of event: Hours <u>[6</u> Da	ys		
7. Remarks:	1		
Patient had to	ecture o	of wedge	cal cabortron vial Ceuter in Dayton,
Ohio for a DH	710 Wa	weds Medi	nat leaven in Day 100,
8. a. Name of physician who provided RU-48	6 Karl	I Schael	for, MD
8. b. Physician's signature <u>Kaul</u>	D. Scle	aeffer	(M.D)D.O
	Date <u>6 (</u>		
Send completed forms to:	State Medica	Board of Ohio	

**Legal Department** 

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127

MEDICAL BOYOR

JUN 1 9 2019

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

1. Date RU-486 was provided:	4	16	19	
-	Month	Day	Year	
2. Name of medical practice or facility at which RU Founders Wouseus	-486 was provi Healt	ded: ( Ceuter		
3. Address of medical practice or facility at w	hich RU-486	was provided:		
1243 East Broad	Street			
colombis, Olio				
4. Date post RU-486 complication began: $5-2-(9)$				
5. Event(s) (Please check all that apply):				
Incomplete abortion Adverse rea	ection to RU-486	Patient hospitalized	ı	
Patient received a transfusion Severe bleeding				
_Other serious event (specify) Failed	Mifep	nex/Olisop	irostol abo	ution
6. Duration of event: Hours 14 Da	ys			
7. Remarks: Patient sout to ou 5/3/19 for so				Dayton, Olero
8. a. Name of physician who provided RU-486	6 <u>Ka</u>	r( I.	schaffer,	cerl
•		2/8e1 2-19	,	
Send completed forms to:	State Medical	Board of Ohio		

**Legal Department** 

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127

MEDICAL BOARD

MAY OR 2015

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	ン	12.	2019
_	Month	Day	Year
2. Name of medical practice or facility at which RU			
The Founder's Women's	·Health	Ceviter.	
		,	
3. Address of medical practice or facility at w		was provided:	
1243 East Broad Street			
Co lumbur, Oliro 4320	2		
4. Date post RU-486 complication began:			
2-18-19			
5. Event(s) (Please check all that apply):			
Incomplete abortion Adverse rea		mata a basa ta t	
Adverse 182	action to RU-486	Patient hospitalized	1
Patient received a transfusionSevere bleeding			
Severe Dieeoing			
7ailed	of Hi	Ferrai	
Other serious event (specify) (R(Cat		<u> </u>	
į			
6. Duration of event: Hours Da	iys		
7. Downston			
7. Remarks: Patient sent to	Wowen	(s Hedle	utei un Day tou, Olas
for saigreal al	eition		
8. a. Name of physician who provided RU-48	6 <u>Ka</u> 1	rl I Schai	effer, wD
8. b. Physician's signature	1 Q. Sc	hae/fer	M.D/D.O
		-(9-19	

Send completed forms to:

State Medical Board of Ohio

**Legal Department** 

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127

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

1. Date RU-486 was provided:	101	24	2019	
	Month	Day	Year	
2. Name of medical practice or facility at which R	U-486 was provide	d:		
Founders Woured	s Health	Le Certe		
3. Address of medical practice or facility at	which DILAGE wa	se providad:		
		is provided.		
1243 E Broad				
Columbus, Olio	43205			
4. Date post RU-486 complication began:				Service Charles
2-5-19				
5. Event(s) (Please check all that apply):				
Adverse r	eaction to RU-486	Patient hospitalized		
Patient received a transfusion Severe bleeding				
Other serious event (specify)				
6. Duration of event: Hours	Days			
7. Remarks: PATTEET has be	tomed:	tissue a	nd wes	
sent to Wome	ens Med	lauter i	u Dayton, Oluò	
8. a. Name of physician who provided RU-4	86 Kar	(I. Sch	auther, and	
8. b. Physician's signature <u>Kae</u>	e D. Sch	acher		
	Date <u>2 ~ (</u>	4-19		
Send completed forms to:	State Medical Bo	oard of Ohio		

**Legal Department** 

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127

MEDICAL BOARD

FEB 1 9 7019

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

1. Date RU-486 was provided:	10	17	19
	Month	Day	Year
2. Name of medical practice or facility at which RL			
The founder's women's	Health "	Gr.	
3. Address of medical practice or facility at w			
1243 E. Broad St. Colu	o, zudmi	H 43205	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
∑Incomplete abortionAdverse realAdverse real	action to RU-486	Patient hospitalize	d
Patient received a transfusion Severe bleeding			
Other serious event (specify)		`	
6. Duration of event: Hours 14 Da	ays		
7. Remarks: fateut had a	Jedal 8	2	ater ) and estar
the uterus Pa	teent	was sent	to Wongers Used
Center in Paybeen	Olico	for a s	urgues abortion.
8. a. Name of physician who provided RU-48	1,	I. Schaeffer,	
8. b. Physician's signature	J. D. G	chaeffer	M.D/D.O
	Date <u> (- ネ</u>	1-19	
Sand completed forms to:			

Send completed forms to:

State Medical Board of Ohio

**Legal Department** 

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

FEB 0 4 2019

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

Date RU-486 was provided:	JAN. Month	03 Dav	2019 Year
2. Name of medical practice or facility	at which RU-486 was provide		
founder's Wome	n's Health Cto	۷.	
3. Address of medical practice or	facility at which PLL 196 w	ac provided:	
1243 E. Broac		as provided.	
4. Date post RU-486 complication			
5. Event(s) (Please check all that a	pply):		
$\chi$ Incomplete abortion $(i)$ $i$	Adverse reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Seve	re bleeding		
Other serious event (specify)			
6. Duration of event: Hour	s <u>13</u> Days		
7. Remarks: fetal demiss	-ph. (eforce t ph. on 1-21.19	i The win	nenis Me& Ctr. In Dayton, CH
8. a. Name of physician who provi	ded RU-486 Karl	Schaetfer,	MO
8. b. Physician's signature	Korl School Date 1-17	Her -19	(M.D)D.O
Send completed forms to:	State Medical Bo	oard of Ohio	
	Legal Department		
	30 E. Broad St., 3 <sup>rd</sup> Floor		
	Columbus, OH 43215-63	127	

Assign and