

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	3		19
	Month	Day	Year
2. Name of medical practice or facility at a Planned Parenthood	which RU-486 was prov	vided:	
3. Address of medical practice or facility at 2314 Auburn Aw.			
4. Date post RU-486 complication began: 3/14/19			
5. Event(s) (Please check all that apply):			
Incomplete abortion A	dverse reaction to RU-486	Patient hospitali	xe d
Patient received a transfusion Severe blee	eding		
POther serious event (specify) on cold		tailed m	eclical 1
6. Duration of event: 2 Hours _	Days		
7. Remarks: Completed Surgical	elz		
a. Name of physician who provided RU-	186 <u>D</u>	Later	
3. b. Physician's signature	Date	M	/0.0
end completed forms to: State N	Medical Board of Ohio		
Legal Departm	ent		MEDICAL BOA
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30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

Prescribed: \$/--/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 provide	d:	5	25	. 0
		Month	Day	Year
2. Name of medical practice Planned Parke		n RU-486 was provid	led:	
3. Address of medical practic				
4. Date post RU-486 complice	ation began:			
5. Event(s) (Please check all t	hat apply):			
Incomplete abortion	Adverse	e reaction to RU-486	Patient hospitalized	
Patient received a transfusion	Severe bleeding			
Other serious event (specify)		7		Construction .
6. Duration of event:	NA Hours	Days		e e e e e e e e e e e e e e e e e e e
7. Remarks: ex cos blood tratment	1055 W/ N rudid o	redication ther them	abortion six,	n. obment
8. a. Name of physician who p	provided RU-486	, 0,	Ka/s;	
8. b. Physician's signature		Villey	(Mg)/D	Ω
	Da	te <u>6/26/</u> /	4	
end completed forms to:	State Medi	cal Board of Ohio		WIN & V SUIC
	Legal Department		100	one
•	30 E. Broad St., 3 rd	Floor	,	HIN & A C.
i	Columbus, OH 432	215-6127		· •

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:		_ 5	25	19
	<u> </u>	Month	Day	Year
2. Name of medical practice of Planned Parent	facility at which R Hood	:U-486 was prov	rided:	
3. Address of medical practice of	or facility at which	RU-486 was pro	vided:	
2314 Auburn				
4. Date post RU-486 complication	on began:			
5. Event(s) (Please check all tha	t apply):			
incomplete abortion	Adverse re	action to RU-486	Patient hospit	alized
Patient received a transfusion	Severe bleeding			
Other serious event (specify)	Failed,	me dical	abortion	
5. Duration of event: 2	_ Hours	Days		
Remarks:	su-gicalle	a without	t.ncidm	+
,				
a. Name of physician who prov	vided RU-486		Kaler	
b. Physician's signature _	Date -	alay 10/20		2/00_
nd completed forms to:	State Medical			
Leg	al Department	· · · · · · · · · · · · · · · · · · ·		
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	ımbus, OH 43215-			LIN & & 2018

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/	9	19
2. Name of medical practice or facility at wl Planned Parenthood	Month hich RU-486 was provid	Day ed:	Year
3. Address of medical practice or facility at v			
4. Date post RU-486 complication began:			
	erse reaction to RU-486	_ Patient hospitalized	
Patient received a transfusion Severe bleedi Other serious event (specify)	ng		
Other serious event (specify)	Days		
Other serious event (specify) Duration of event: Hours Remarks: Hours A. Remarks: Hours A. Remarks: Hours Del perfer need wo for the control of the con	Days	Ka/17 (M)/1	L

30 E. Broad St., 3rd Floor Columbus, OH 43215-6127

MEDICAL BOARD

DEC 1 6 2019



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	8	28	19	
	Month	Day	Year	
2. Name of medical practice or facility at a Planned Parenthood	which RU-486 was pro	vided:		
3. Address of medical practice or facility at 2314 Auburn Au.		아이터에 가다고		
4. Date post RU-486 complication began: 9/12/19				
5. Event(s) (Please check all that apply):				
∠ Incomplete abortion A	dverse reaction to RU-486	Patient hospitaliz	ed	
Patient received a transfusion Severe ble	eding			
Other serious event (specify)				
6. Duration of event: 2 Hours _	Days			
7. Remarks: Completed Surgica	dy w/0 ,nc	ident.		
8. a. Name of physician who provided RU-	486 /	De Kalsa		
8. b. Physician's signature	Mally Date \$118/	19	/0.0	
Send completed forms to: State	Medical Board of Ohio			أحيين وجود
Legal Departr	nent	ا نسبت د.	ICAL BOARD)
30 E. Broad S	t., 3 rd Floor	MED	IVAL "	
Columbus O	1 43215-6127	:	10 T S € 7 W	