



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:	<u>1</u>	<u>17</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood</u>		
3. Address of medical practice or facility at which RU-486 was provided:	<u>2314 Auburn Ave. Cincinnati, OH 45219</u>		
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event:	<u>2</u> Hours	_____ Days	
7. Remarks:	<u>D+C done</u>		
8. a. Name of physician who provided RU-486	<u>Dr. Parke</u>		
8. b. Physician's signature	<u>[Signature]</u>	_____	MD/DO
	Date	<u>2/14/19</u>	_____

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:	6	6	19
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <i>Planned Parenthood</i>			
3. Address of medical practice or facility at which RU-486 was provided: <i>2314 Auburn Ave. Cincinnati, OH 45219</i>			
4. Date post RU-486 complication began: <i>6/27/19</i>			
5. Event(s) (Please check all that apply):			
<input checked="" type="checkbox"/> Incomplete abortion/failed <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <i>2</i> Hours _____ Days			
7. Remarks: <i>Completed surgically</i>			
8. a. Name of physician who provided RU-486: <i>Dr. Pensak</i>			
8. b. Physician's signature: _____ <i>[Signature]</i> <i>MD/DO</i>			
Date: <i>7/19/19</i>			

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State Medical Board of Ohio Report of RU-486 Event

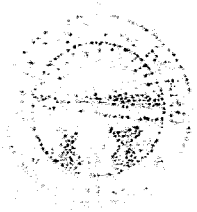
(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	6	27	19
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <i>Planned Parenthood</i>			
3. Address of medical practice or facility at which RU-486 was provided: <i>2314 Auburn Ave. Cincinnati, OH 45219</i>			
4. Date post RU-486 complication began: <i>7/19/19</i>			
5. Event(s) (Please check all that apply):			
<input checked="" type="checkbox"/> Incomplete abortion / <i>Failed</i> <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <i>2</i> Days			
7. Remarks: <i>Completed surgically</i>			
8. a. Name of physician who provided RU-486 <i>Dr. Pearce</i>			
8. b. Physician's signature <i>[Signature]</i> <i>MD/DO</i>			
Date <i>7/19/19</i>			

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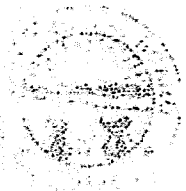
(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>2</u> Month	<u>14</u> Day	<u>19</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>3/1/19</u>			
5. Event(s) (Please check all that apply):			
<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> ^{treatment time} Hours _____ Days			
7. Remarks: <u>Completed surgically</u>			
8. a. Name of physician who provided RU-486 <u>M. Conde</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O.			
Date <u>3/13/19</u>			

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

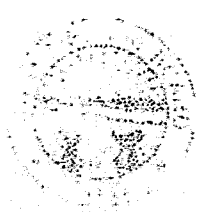
1. Date RU-486 was provided:	<u>10</u>	<u>24</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <i>Planned Parenthood</i>			
3. Address of medical practice or facility at which RU-486 was provided: <i>2314 Auburn Ave. Cincinnati, OH 45219</i>			
4. Date post RU-486 complication began: <i>11/9/19</i>			
5. Event(s) (Please check all that apply):			
<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <i>completed surgically.</i>			
8. a. Name of physician who provided RU-486 <i>Dr. Pansale</i>			
8. b. Physician's signature _____ <i>(Signature)</i> <u>MD/DO</u>			
Date <u>11/22/19</u>			

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NOV 29 2019



State Medical Board of Ohio Report of RU-486 Event

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To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 6 / 28 / 19
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cincinnati, OH 45219

4. Date post RU-486 complication began:
~~6/30/19~~ 7/2/19

5. Event(s) (Please check all that apply):
 Incomplete abortion / Failed Adverse reaction to RU-486 Patient hospitalized
 Patient received a transfusion Severe bleeding
 Other serious event (specify) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks:
Completed surgically.

8. a. Name of physician who provided RU-486: Dr. Prusak
 8. b. Physician's signature: [Signature] M.D./D.O.
 Date: 7/19/19

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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:	<u>2</u> Month	<u>14</u> Day	<u>19</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>2/26/19</u>			
5. Event(s) (Please check all that apply):			
<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> ^{hr} ^{time} Hours _____ Days			
7. Remarks: <u>D+C done in office</u>			
8. a. Name of physician who provided RU-486 <u>M. Pasch</u>			
8. b. Physician's signature _____ <u>MD/DO</u>			
Date <u>3/22/19</u>			

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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 / 12 / 19
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cincinnati, OH 45219

4. Date post RU-486 complication began:
9/26/19

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: 2 Hours _____ Days

7. Remarks:
Failed med Ab - completed surgically w/ no issue

8. a. Name of physician who provided RU-486 Dr. Bensch

8. b. Physician's signature [Signature] MD/DO

Date 10/25/19

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 OCT 30 2019