

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:		17	19	
	Month	Day	Year	
2. Name of medical practice or facility a Planned Parenthood		ded:		
3. Address of medical practice or facility	at which RU-486 was pro-	vided:		
2314 Auburn Au.	lina, of	45219		
4. Date post RU-486 complication began				
5. Event(s) (Please check all that apply):				
L'Incomplete abortion	Adverse reaction to RU-486	Patient hospitalize	d	
Patient received a transfusion Severe }	pleeding			
Other serious event (specify)				
6. Duration of event: 2 Hours	Days			
7. Remarks:				
8. a. Name of physician who provided Ri	ال ا	Port		
8. b. Physician's signature	D.	MD/	D O	
	Date2110			
Send completed forms to: State	e Medical Board of Ohio			
Legal Depar	tment			
30 E. Broad	St., 3 <sup>rd</sup> Floor			
Columbus (	OH 43215-6127			



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To be completed by the physician who provided RU-486

1. Date RU-486 was pro	ovided:	6	L	19
		Month	Day	Year
2. Name of medical pra	ectice or facility at wh Menthool	ich RU-486 was provid	led:	
3. Address of medical pr	actice or facility at w	hich BILASS was need		
2314 Aubu				
4. Date post RU-486 com				
5. Event(s) (Please check	all that apply):			
Pincomplete abortion/Fa				
- incomplete aportion/ 74	Adver	se reaction to RU-486	Patient hospitaliz	ed
Patient received a transfu	sion Severe bleeding			
		<b>5</b>		
Other serious event (speci	fv)			
5. Duration of event:	2 Hours			
		Days		
7. Remarks:	1	and the same of th		
Camp 1110	so grally			
	•			
a. Name of physician wh	o provided pursoe		<i></i>	
	o provided RU-486	- Or 0	ansale	
b. Physician's signature			- CO2/	2.0
	Dat	ie	19/19	
nd completed forms to:	State Medic	al Board of Ohio		
े प्राप्त क्लाहे । विकास क्लाहे				
	Legal Department			-
		Floor		CAL BOAF
	Legal Department 30 E. Broad St., 3 <sup>rd</sup> Columbus, OH 432			MEDICAL BOAF



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:		27	19
2. Name of medical practice or facility: Planned Parenthood	at which RU-486 was provid	Day led:	Year
3. Address of medical practice or facility 2314 Auburn Am.	at which RU-486 was provi	ded: 4.C219	
1. Date post RU-486 complication began			
Dincomplete abortion / Faild —	Adverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe by Other serious event (specify)			
Patient received a transfusion Severe b	leeding		
Patient received a transfusion Severe byOther serious event (specify)  Duration of event: Hours	leeding  2 Days		
Patient received a transfusion Severe byOther serious event (specify)  Duration of event: Hours  Remarks: Completed Surg	leeding  2 Days gically		
Patient received a transfusion Severe byOther serious event (specify)  Duration of event: Hours	leeding  2 Days  gically		

Legal Department

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

Columbus, OH 43215-6127

MEDICAL BOARD JUL 2 4 2019



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

		14	19
	Month	Day	Year
2. Name of medical practice or facility at a Planned Parenthood	which RU-486 was provid	ed:	
3. Address of medical practice or facility at 2314 Auburn Au.			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
uIncomplete abortionAd	lverse reaction to RU-486 _	Patient hospitalized	
Patient received a transfusion Severe blee	ding		
Other serious event (specify)			
Other serious event (specify)	ut time 		
	ut time Days		

**Legal Department** 

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

Columbus, OH 43215-6127

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	/0	24	16	
	Month	Day	Year	-
2. Name of medical practice or facility at w Planned Parenthood	hich RU-486 was provic	led:		
3. Address of medical practice or facility at	which RU-486 was prov	ided:		
2314 Auburn Au.	Una, of	45219		
4. Date post RU-486 complication began: $11/9/19$				
5. Event(s) (Please check all that apply):				
∠ Incomplete abortionAdv	verse reaction to RU-486	Patient hospitalized		
Patient received a transfusion Severe bleed	ding			
Other serious event (specify)				
6. Duration of event:2 Hours	Days		· · · · · · · · · · · · · · · · · · ·	
7. Remarks: completed surpeally	<b>L</b>			
8. a. Name of physician who provided RU-48 8. b. Physician's signature	86 Dr	Pansale MOVIE	).O	
	Date	6		
and completed forms to:				

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

NOV 2 9 2019



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	_ 4	28	19
2. Name of medical practice or facility at w Planned Parenthood	Month hich RU-486 was provid	Day ded:	Year
3. Address of medical practice or facility at a 2314 Auburn Au.	which RU-486 was provi	ided: 4:(2/9	
4. Date post RU-486 complication began:  Let 3-119 error 7/2			
Event(s) (Please check all that apply):	erse reaction to RU-486	Patient hospitalized	
Other serious event (specify)  Duration of event: Hours	Days		
Remarks: Completed Surjeal	ely.		
. Name of physician who provided RU-486	0.	Pensak	
o. Physician's signature	9	MOZOCO	
Da	ate	419118	

Legal Department

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

Columbus, OH 43215-6127

MEDICAL BOARD

AUG 0 2 2019



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was pro	ovided:	2	14	10
		Month	Day	Year
2. Name of medical pra	ctice or facility at which RU Wenthool	-486 was provi	ded:	
	ractice or facility at which RI			
4. Date post RU-486 con	oplication began:	19		
5. Event(s) (Please check				
✓Incomplete abortion	Adverse reac	tion to RU-486	Patient hospitalized	
Patient received a transfu	usionSevere bleeding			
Other serious event (spec	ify)			
6. Duration of event:	2 tx time Hours0	ays		
7. Remarks:				
D = ( d	on in office			
D → C d  3. a. Name of physician w		p	r fasole	
	ho provided RU-486		Pasole (MD/D)	<b>.</b>
3. a. Name of physician w 3. b. Physician's signature	ho provided RU-486  Date —	3/24/19	MD/D	<b>o</b>
3. a. Name of physician w 3. b. Physician's signature	ho provided RU-486  Date —  State Medical Bo	3/24/19	MD/D	SOID MAR 29
3. a. Name of physician w	ho provided RU-486  Date —	3/22/19 pard of Ohio	92 :01 MA	STATE MEDI



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	9	/2	19
	Month	Day	Year
2. Name of medical practice or facility Planned Parknthoo		vided:	
3. Address of medical practice or facil 2314 Auburn Au		기계를 받는 그	
4. Date post RU-486 complication beg	tan: U / 19		
5. Event(s) (Please check all that apply	n:		
✓ Incomplete abortion	Adverse reaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion Seve	re bleeding		
Other serious event (specify)			The state of the s
6. Duration of event: Hou	rs Days		
7. Remarks: Failed med As - a	empleted erryica	ally wis is	Sur
8. a. Name of physician who provided	The state of the s	Dr. Bins	ok
8. b. Physician's signature	Male 101	25/19 (10)	<b>7 D.O</b>
Send completed forms to: S	tate Medical Board of Ohio		
Legal De	partment	(	MEDICAL BOARD
30 E. Bro	ad St., 3 <sup>rd</sup> Floor	,	OCT 3 6 2019
بالمناب المناخ	- OH 42215 6127		Mr. O. A. String

Columbus, OH 43215-6127