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) 26 (Day) 2018 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Captal Care Network Toledo

3. Address of medical practice or facility at which RU-486 was provided:
1160 W. Sylvania Ave.
Toledo, OH 43612

4. Date post RU-486 complication began:
02/20/2018

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: 4 Hours Ø Days

7. Remarks: Incomplete Med. Ab. D&C completed. K complications

8. a. Name of physician who provided RU-486 Dr. L. Ann Nunnally

8. b. Physician's signature L. A. Nunnally MD M.D/D.O

Date 02/20/2018

Send completed forms to:

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

MEDICAL BOARD
APR 13 2018

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: Oct (Month) 28 (Day) 17 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Capital Care Network Toledo

3. Address of medical practice or facility at which RU-486 was provided:
1100 N Sylvania Ave
Toledo OH 43612

4. Date post RU-486 complication began:
3/9/17

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 1 Days

7. Remarks:
Pt in for suction (D+C) after incomplete Med AB. Ø complications

8. a. Name of physician who provided RU-486 Dr. David Burkons MAA1224

8. b. Physician's signature _____ (M.D/D.O___)

Date 03/09/18

Send completed forms to:

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

MEDICAL BOARD

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: 04 (Month) 27 (Day) 2018 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Capital Care Network of Toledo

3. Address of medical practice or facility at which RU-486 was provided:
1160 W. Sylvania Ave.

4. Date post RU-486 complication began:
06-02-18

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: 5 Hours ____ Days

7. Remarks: Incomplete Med ab. pt requests d+c. D+C completed. ✓ Complications

WIK0819

8. a. Name of physician who provided RU-486 _____

8. b. Physician's signature L. A. Mallay MD M.D/D.O

Date 06/02/18

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

JUN 11 2018

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) | 10 (Day) | 2018 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Capital Care Network Toledo

3. Address of medical practice or facility at which RU-486 was provided:
1160 W. Sylvania Ave Toledo OH 43612

4. Date post RU-486 complication began:
05/23/2018

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed Medical Abortion

6. Duration of event: ____ Hours 2 Days

7. Remarks: Surgical abortion completed on 05/25/2018.

GUK0730

8. a. Name of physician who provided RU-486 Dr. Lucy Ann Nunnally

8. b. Physician's signature Lucy Nunnally MD (M.D./D.O.)

Date 5/25/18

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

JUN 11 2018

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) 07 (Day) 18 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Capital Care Network of Toledo

3. Address of medical practice or facility at which RU-486 was provided:
1160 W. Sylvania Ave. Toledo, OH 43612

4. Date post RU-486 complication began:
06/12/18

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: 2 Hours _____ Days

7. Remarks: Incomplete Med. MB. D&C completed. ∅ complications

NOA 0927

8. a. Name of physician who provided RU-486 Dr. L. Ann Nunnally

8. b. Physician's signature [signature] MD (M.D/D.O)

Date 06/12/18

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

JUN 26 2018

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: 08 (Month) 08 (Day) 18 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Capital Care Network Toledo

3. Address of medical practice or facility at which RU-486 was provided:
1160 W. Sylvania Ave Toledo, OH 43612

4. Date post RU-486 complication began:
08-15-18

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) failed medical abortion

6. Duration of event: ____ Hours 1 Days

7. Remarks:

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

8. b. Physician's signature _____ M.D/D.O

Date 8/17/18

Send completed forms to:

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

MEDICAL BOARD

AUG 29 2018

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: 06 (Month) 12 (Day) 2018 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Capital Care Network Toledo

3. Address of medical practice or facility at which RU-486 was provided:
1160 W. Sylvania Ave. Toledo, OH 43612

4. Date post RU-486 complication began:
08-13-18

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 1 Days

7. Remarks: Incomplete medical abortion

8. a. Name of physician who provided RU-486 Dr. Lucy Ann Nunnally

8. b. Physician's signature L. A. Nunnally MD

Date 8/25/18 M.D/D.O

Send completed forms to:

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

MEDICAL BOARD

AUG 29 2018

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: 08 (Month) 01 (Day) 2018 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Capital Care Network of Toledo

3. Address of medical practice or facility at which RU-486 was provided:
1160 W. Sylvania Ave.
Toledo, OH 43612

4. Date post RU-486 complication began:
08/27/2018

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 1 Days

7. Remarks: Incomplete med. AB.
Sx d+c performed. No further issues

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

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

Date 08/31/18

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

SEP 24 2018

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) 19 (Day) 2018 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Capital Care Network of Toledo

3. Address of medical practice or facility at which RU-486 was provided:
1160 W Sylvania Ave.
Toledo, OH 43612

4. Date post RU-486 complication began:
11-19-18

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: 3 Hours _____ Days

7. Remarks:
COH 0922

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

8. b. Physician's signature _____ M.D/D.O

Date 11/3/19

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

DEC 13 2018