1. Date RU-486 was provided:	C١	26	2018	
	Month	Day	Year	
2. Name of medical practice or facil Capital Care W	ity at which RU-486 was pro etwo: IC Teled	vided: ਹ		
3. Address of medical practice of 1160 W. Sylvian Ka	or facility at which RU-480	6 was provided:		
4. Date post RU-486 complication () 2 / 20 / 2018	on began:			
5. Event(s) (Please check all tha	t apply):			
ncomplete abortion	Adverse reaction to RU-486	Patient hospitali	zed	
Patient received a transfusion S	evere bleeding			
Other serious event (specify)			<del>ang panalah manalah kalan</del> ah merenjalah men	
6. Duration of event: 4 Ho	urs Days			
7. Remarks: Incomprete	med An. DEC	compreted	. K conflict	· · · ·
8. a. Name of physician who pr	ovided RU-486	T. L. Am 1		
8. b. Physician's signature	Date	(My M) 2/20/2018	M.D/D.O	-
Send completed forms to:	State Medic	al Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 <sup>rd</sup> F	loor iV	EDICAL BUNKE	
	Columbus, OH 4321	15-6127	APR 1.3 20:8	

## State Medical Board of Ohio Report of RU-486 Event

1. Date RU-486 was provided:	_ Oi4	ેજ.	31	
2. Name of medical practice or facility a	Month	Day	Year	
and the state of medical practice of facility a	L WINCH KU-486 Was provi	ded:		
Captal Cine Netwood	IL Talkelo			
3. Address of medical practice or fa	cility at which RU-486	was provided:		
116 byl Sylvinia Are				•
Totado OH 43412				•
4. Date post RU-486 complication b	egan:			
5. Event(s) (Please check all that ap	ply):			
✓ Incomplete abortion	Adverse reaction to RU-486	Patient hospitalized		
Patient received a transfusion Severe	£			
Patient received a transfusion Severe	Dieeding			
Other serious event (specify)				
5. Duration of event: Hours	1 0			
nous	Days			
7. Remarks:	file incomple	to Meddo.	d couplications	
		7		
			MAAIZZ	4
3. a. Name of physician who provide	d RU-486 D.7.	Devid Buck		
B. b. Physician's signature	21 1/1		MADIDA	
	Date 031	39/1E	(M.D/D.O	
nd completed forms to:	State Medical I	Board of Ohio		
,	Legal Department			
	30 E. Broad St., 3 <sup>rd</sup> Floo			
(	Columbus, OH 43215-6	5127	· ARTOLOAL	56455
			MEDICAL	. BOARD

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	04	27	2018	
	Month	Day	Year	
2. Name of medical practice or facility at which	RU-486 was provide	ed:		
Capital Care Network of	Tolecto			
3. Address of medical practice or facility	at which RU-486 w	as provided:		
1160 W. Sylvania Ave.	er te in 12 Meser en 2 se i •			
4. Date post RU-486 complication began:				
5. Event(s) (Please check all that apply):				
Incomplete abortionAdver	se reaction to RU-486	Patient hospitaliz	eed	
	•			
Patient received a transfusionSevere bleedi	ng			
Other serious event (specify)				
				***
6. Duration of event: 5 Hours	Days			
o. Buration of events.				
7. Remarks: Incomplete mud a Dic completed of	b. pt requis	rdre.		
Dic confletedis	compaction	>	1 = 4 001G	
			WIK0819	
8. a. Name of physician who provided RU	J-486 /1	\ Z		
~	11/1	1. 410		
8. b. Physician's signature	Date Olo i	22 18	(M.D/D.O	

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

JUN 11 2018

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	05	10	2018	
	Month	Day	Year	
2. Name of medical practice or facility	at which RU-486 was provi	ided:		
Capital Core	Wetwerk To	ile do		
3. Address of medical practice or f	acility at which RU-486	was provided:	eries de la companya	
1160 W. Sylvania	a He Toled	.o CH 431	612	· ·
4. Date post RU-486 complication 05 23 20	began: ( 원			
5. Event(s) (Please check all that a	pply):			
Incomplete abortion	Adverse reaction to RU-486	Patient hospitalize	ed	
Patient received a transfusion Seve	ere bleeding			
Other serious event (specify)	Failed med	ical Aborti	(بر	
6. Duration of event: Hour	s <u>2</u> Days			
7. Remarks: Surgical (05/25/2018)	abortion com	puted on		
0.1201				GUK0730
8. a. Name of physician who prov	ided RU-486 Dr	Lucy And	Nunnal	
8. b. Physician's signature	Date 5	ly MD 125/18	(M.D)/D.O	
Send completed forms to:	State Medic	al Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 <sup>rd</sup> F	loor		

Columbus, OH 43215-6127

MEDICAL BOARD

JUN 11 2018

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	05	<u>01</u>	1 8 Year	
	Month			
2. Name of medical practice or facility at which				
Capital Care Wetwork	·f Tole	lo		
3. Address of medical practice or facility a	t which RU-486	was provided:		
1160 W. Sylvania Are	. Toledo,	OH 43617	L	
4. Date post RU-486 complication began: $06/12/18$				
5. Event(s) (Please check all that apply):				
✓ Incomplete abortion Advers	e reaction to RU-486	Patient hospital	ized	
Patient received a transfusion Severe bleedin	8			
Other serious event (specify)				
6. Duration of event: 2 Hours				
7. Remarks: Incomplete Med,	AB . D+C	Coupletal	. of complice	HON
			NOA	6927
8. a. Name of physician who provided RL  8. b. Physician's signature	J-486 Dr. Date 06	Ly Am 1 elly MD 12/18	Junnally M.D/D.O_	

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
JUN 2 6 2018

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	08	08	18	
	Month	Day	Year	
2. Name of medical practice or facility at w  Capital Care	hich RU-486 was provided to Netwo		0.	
3. Address of medical practice or facility (60 W. 5yl vania			43612	
4. Date post RU-486 complication beg  \[ \begin{align*} \chi \leq -\5 - \8 \\  \end{align*}  5. Event(s) (Please check all that apply)	an:			
	verse reaction to RU-486	Patient hospitalized		
Patient received a transfusionSevere blee	eding	al abortio	<u>N</u>	
6. Duration of event: Hours/	Days			
7. Remarks:				
/				
8. a. Name of physician who provided t	10-486 Dr.	David Bu	irkons	
8. b. Physician's signature \(\frac{\int}{2}\)	Date 8/1/	18	_M.D/D.O	
end completed forms to:	State Medical B	oard of Ohio		and a superior of the superior
lea	al Denartment			

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

Columbus, OH 43215-6127

MEDICAL BOARD

AUG 29 2018

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

	3 \ 7			
	<u>Ο</u> <u>ω</u>	12	2018	
2. Name of medical practice or facility at	Which RU-486 was 11	Day	Year	
Capital Care Le	twork To lede	)		
3. Address of medical practice or fac	ility at which RU-486 wa	S provided		
	NE. Weday	OH 4361	2	
4. Date post RU-486 complication beginning $09-13-18$				
Event(s) (Please check all that apply	y):			
	dverse reaction to RU-486	_ Patient hospitalized		
Patient received a transfusionSevere bis	eeding			
Other serious event (specify)				÷
Duration of event: Hours	Days			
	3 Days			
Remarks: Incomplete me	dical about			
Remarks: Incomplete me	dical abortion	S	•	
Remarks: Incomplete me	dical abortion	S		
			•	
a. Name of physician who provided p		y Amn Dy	nnally	
Remarks: Incomplede me a. Name of physician who provided R b. Physician's signature	br. Luc	y Amn Dy	nnolly	
a. Name of physician who provided B	Date	4 Amn Du 1D 8/25/18 (N		
a. Name of physician who provided B	Date	4 Amn Du 1D 8/25/18 (N		
a. Name of physician who provided Reb. Physician's signature completed forms to:	10-486 Dr. Luc	4 Amn Du 1D 8/25/18 (N		
a. Name of physician who provided Rob. Physician's signature  completed forms to:	Date State Medical Board	4 Amn Du 1D 8/25/18 (N		

MEDICAL BOARD

AUG 29 2018

1. Date RU-486 was provided:	69	01	2018	
	Month	Day	Year	
2. Name of medical practice or facility at Capital Care Ret				
3. Address of medical practice or far 1160 W. Sylv ANIA Toledo, OH 4361	AUE.	was provided:		
		1,	Ì.	
4. Date post RU-486 complication be 08 / 27 / 2018	egan:			
5. Event(s) (Please check all that app	oly):			
Incomplete abortion	Adverse reaction to RU-486	Patient hospitaliz	ed	
Patient received a transfusion Severe	bleeding			
Other serious event (specify)				
6. Duration of event: Hours	Days			
7. Remarks: 1 Complete O	rd. As.	•.		
7. Remarks: 1 Nowuplete 17  5x d+c per	formed. Of	urther 1554	es	
8. a. Name of physician who provide	dellage De l	band Bu		
C strains of physician who provide	WALL TO THE PARTY OF THE PARTY	JOHO DU	( K3 N.)	The state of the s
8. b. Physician's signature	Date ON	31/18	(M.d/d.o	
end completed forms to:	CA-A-A-A-A-A-A-A-A-A-A-A-A-A-A-A-A-A-A-			
	State Medical (	Board of Ohio		
ı	Legal Department			
3	30 E. Broad St., 3 <sup>rd</sup> Floo	r	nav	
C	Columbus, OH 43215-	5127	MEDICAL BOARD	
			SEP & 4 2018	

1. Date RU-486 was provided:	10 Month	PI	3105
2. Name of medical practice or facility at which	1,12,5,5,5,5,7,1	Day	Year
Capital Care Nietw			
3. Address of medical practice or facility: 1160 W Sylvania Aug Toledo, OH 43612	at which RU-486 was	provided:	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Incomplete abortionAdversPatient received a transfusionSevere bleeding	se reaction to RU-486	_Patient hospitalized	
Other serious event (specify)			
6. Duration of event: 3 Hours	_ Days		
7. Remarks:	<u>, , , , , , , , , , , , , , , , , , , </u>		(OH 0922
8. a. Name of physician who provided RU  8. b. Physician's signature	Date	C/ly	(M,0/D.O)
iend completed forms to:	State Medical Boa	$\mathcal{U}$ rd of Ohio	
Legal	Department		
30 E.	Broad St., 3 <sup>rd</sup> Floor		
Colun	nbus, OH 43215-612	7	MEDICAL BOARD
			DEC 1 3 2018