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: MAY (Month) 29 (Day) 2018 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
EAST COLUMBUS HEALTH CENTER

3. Address of medical practice or facility at which RU-486 was provided:
3255 EAST MAIN STREET COLUMBUS, OH 43213

4. Date post RU-486 complication began: 6/7/18

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: _____ Hours 9 Days

7. Remarks: INCOMPLETE MEDICAL ABORTION, TREATED W/ ASPIRATION

8. a. Name of physician who provided RU-486: KATHERINE RIVLIN

8. b. Physician's signature: KRivlin MD/DO

Date: 11/20/18

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

Prescribed: 5/--/2011, Rev. 12/13/12

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: 3 (Month) 16 (Day) 2018 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
East Columbus Health Center

3. Address of medical practice or facility at which RU-486 was provided:
3255 East Main Street Columbus OH 43213

4. Date post RU-486 complication began: 3/23/2018

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 7 Days

7. Remarks: INCOMPLETE MEDICAL ABORTION, ~~SO~~ TREATED W/ ASPIRATION

8. a. Name of physician who provided RU-486 Isley, Michelle

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

Date 11/30/18

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

Prescribed: 5/--/2011, Rev. 12/13/12

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: May (Month) 18 (Day) 2018 (Year)

2. Name of medical practice or facility at which RU-486 was provided: East Columbus Surgical Center

3. Address of medical practice or facility at which RU-486 was provided: 3255 East Main Street Columbus, Ohio 43213

4. Date post RU-486 complication began: 5-29-18

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) Failed Medical Abortion

6. Duration of event: # Hours 11 Days

7. Remarks: Failed Medical Abortion, treated w/ Aspiration

8. a. Name of physician who provided RU-486 Michelle Isley

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

Date 6/3/18

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

Prescribed: 5/--/2011, Rev. 12/13/12

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: June (Month) 21 (Day) 2018 (Year)

2. Name of medical practice or facility at which RU-486 was provided: East Columbus Health Center

3. Address of medical practice or facility at which RU-486 was provided: 3255 East Main Street Columbus, OH 43213

4. Date post RU-486 complication began: 7/2/2018

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) Failed Medical Abortion

6. Duration of event: _____ Hours 11 Days

7. Remarks:

8. a. Name of physician who provided RU-486 Michelle Isley

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

Date 11/30/18

Send completed forms to:

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

MEDICAL BOARD

Prescribed: 5/--/2011, Rev. 12/13/12

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: June (Month) 29 (Day) 2018 (Year)

2. Name of medical practice or facility at which RU-486 was provided: East Columbus Health Center

3. Address of medical practice or facility at which RU-486 was provided: 3255 East Main Street Columbus, Ohio 43213

4. Date post RU-486 complication began: 7/6/18

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) Failed Medical Abortion

6. Duration of event: _____ Hours 7 Days

7. Remarks:

8. a. Name of physician who provided RU-486 Michelle Isley,

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

Date 11/30/18

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

Prescribed: 5/--/2011, Rev. 12/13/12

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: August (Month) 31 (Day) 2018 (Year)

2. Name of medical practice or facility at which RU-486 was provided: East Columbus Health Center

3. Address of medical practice or facility at which RU-486 was provided: 3255 East Main St. Columbus, OH 43213

4. Date post RU-486 complication began: 9-14-18

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 14 Days

7. Remarks:

8. a. Name of physician who provided RU-486 Michelle Isley

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

Date 11/30/18

Send completed forms to:

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

Prescribed: 5/--/2011, Rev. 12/13/12

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: AUGUST (Month) 15 (Day) 2018 (Year)

2. Name of medical practice or facility at which RU-486 was provided: East Columbus Health Center

3. Address of medical practice or facility at which RU-486 was provided: 3255 East Main Street

4. Date post RU-486 complication began: 9/4/18

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: _____ Hours 19 Days

7. Remarks:

8. a. Name of physician who provided RU-486 Anne-Marie Sinay

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

Date 11-29-18

Send completed forms to:

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

Prescribed: 5/--/2011, Rev. 12/13/12

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: Jan (Month) 22 (Day) 2018 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St
Columbus OH 43213

3255 E. Main St.
Columbus OH 43213

4. Date post RU-486 complication began: 1/26

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 MAB

6. Duration of event: 2 Hours 0 Days

7. Remarks:
uncomplicated Dilation: suction

8. a. Name of physician who provided RU-486 Catharine Romanos

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

Date 2/7/18

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

MEDICAL BOARD
FEB 12 2018

Prescribed: 5/--/2011, Rev. 12/13/12

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: 1 (Month) 30 (Day) 18 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St.
Columbus OH 43213

4. Date post RU-486 complication began: 2/8/18

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 MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date _____

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

MEDICAL BOARD

Prescribed: 5/--/2011, Rev. 12/13/12

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: Feb (Month) 19 (Day) 2018 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St.
Columbus OH 43213

4. Date post RU-486 complication began: 2/28/18

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 _____ Days

7. Remarks:
uncomplicated suction

8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature _____ MD/DO

Date 3/8/18

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

MEDICAL BOARD

Prescribed: 5/--/2011, Rev. 12/13/12

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: January (Month) 29 (Day) 2018 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St.
Columbus OH 43213

4. Date post RU-486 complication began: 3/21/18

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 MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks: uncomplicated D&E

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 3/29/18

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

MEDICAL BOARD

Prescribed: 5/--/2011, Rev. 12/13/12

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: Feb (Month) 21 (Day) 2018 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St.
Columbus OH 43213

4. Date post RU-486 complication began: 2/28 - 2nd dose miso given,
3/8 - suction done

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 _____ Days

7. Remarks:

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

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

Date 3-28-18

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 R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: March (Month) 22 (Day) 2018 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus OH 43213

4. Date post RU-486 complication began: 4/5/18

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 abortion

6. Duration of event: _____ Hours _____ Days

7. Remarks: complicated suction

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 4/19/18

Send completed forms to:

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

MEDICAL BOARD

APR 20 2018

Prescribed: 5/--/2011, Rev. 12/13/12

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: April (Month) 2 (Day) 2018 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St Columbus OH 43213

4. Date post RU-486 complication began: 4/6/18

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 _____ Days

7. Remarks: Uncomplicated D + E

8. a. Name of physician who provided RU-486: Colin McCluney

8. b. Physician's signature: _____ MD/DO

Date 4/30/18

Send completed forms to:

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

MEDICAL BOARD
MAY 03 2018

Prescribed: 5/--/2011, Rev. 12/13/12

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: April (Month) 19 (Day) 2018 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St.
Columbus OH 43213

4. Date post RU-486 complication began: 4/24/18

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 _____ Days

7. Remarks:
Uncomplicated D&C

8. a. Name of physician who provided RU-486 Katherine Romanos

8. b. Physician's signature _____ MD/DO

Date 5/3/18

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

MEDICAL BOARD
MAY [illegible] 2018

Prescribed: 5/--/2011, Rev. 12/13/12

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: April (Month) 24 (Day) 2018 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St.
Columbus OH 43213

4. Date post RU-486 complication began:
May 3, 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 MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks:
Failed MAB,
Uncomplicated D&C done

8. a. Name of physician who provided RU-486 Katy Rivlin

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

Date 5/8/18

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

MEDICAL BOARD
MAY 11 2018

Prescribed: 5/--/2011, Rev. 12/13/12

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: 5 (Month) 9 (Day) 18 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St.
Columbus OH 43213

4. Date post RU-486 complication began: 5/7/18

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 MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Michelle Isley

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

Date 6/14/18

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

MEDICAL BOARD

Prescribed: 5/--/2011, Rev. 12/13/12

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: 05 (Month) 25 (Day) 18 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St.
Columbus OH 43213

4. Date post RU-486 complication began: 6/4/18

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 MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Michelle Isley

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

Date 6/14/18

Send completed forms to: State Medical Board of Ohio
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30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

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Prescribed: 5/--/2011, Rev. 12/13/12