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: 03 (Month) 02 (Day) 2018 (Year)

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

Founders Womens HealthCenter

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

1243 E. BROAD ST Columbus Ohio 43205

4. Date post RU-486 complication began:

03-16-18

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~~ 20.1 Hours ø Days

7. Remarks:

8. a. Name of physician who provided RU-486 Harley Blank MD

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

Date 3-16-18

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: 9 (Month) 20 (Day) 2018 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
The Founder's Women's Health Center

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad Street Columbus, Ohio 43205

4. Date post RU-486 complication began:
10-4-18

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) Failed Abortion, fetal demise

6. Duration of event: ____ Hours 15 Days

7. Remarks: Patient had failed abortion and was sent to The Women's Med Center in Dayton, Ohio for surgical abortion on 10/23/18

8. a. Name of physician who provided RU-486 Karl I. Schaeffer, MD

8. b. Physician's signature Karl I. Schaeffer M.D/D.O

Date 11-14-18

Send completed forms to:

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

MEDICAL BOARD
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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: 09 (Month) 20 (Day) 2018 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
The Founder's Women's Health Center

3. Address of medical practice or facility at which RU-486 was provided:
1243 E Broad Street Columbus, Ohio 43205

4. Date post RU-486 complication began:
10-8-18

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

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

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) Failed Abortion

6. Duration of event: ____ Hours 26 Days

7. Remarks:
Patient was sent to Women's Med Center in Dayton, Ohio on 10/24/18 for surgical abortion.

8. a. Name of physician who provided RU-486 Karl I. Schaeffer, MD

8. b. Physician's signature Karl I. Schaeffer (M.D./D.O.)
Date 11-14-18

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 ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 5.31.18 — May (Month) 31 (Day) 2018 (Year)

2. Name of medical practice or facility at which RU-486 was provided: Founder's Women's Health Center

3. Address of medical practice or facility at which RU-486 was provided: 1243 E. Broad St. Columbus, Ohio 432

4. Date post RU-486 complication began: 6.16.18

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: 0.1 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486: Harley Blank MD

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

Date 6.16.18

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

2. Name of medical practice or facility at which RU-486 was provided:
Founder's Women's Health Center

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St. Columbus, Ohio 43205

4. Date post RU-486 complication began:
6.18.18

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: 0.1 Hours ____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Harley Blank MD

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

Date 6.18.18

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: 3 (Month) 28 (Day) 18 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Founders Women's Health Center

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St., Columbus OH 43205

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

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: 0.1 Hours _____ Days

7. Remarks:
Gestational sac visualized on U/S 4.11.18.
Managed w/ D&C. Pt tolerated well.

8. a. Name of physician who provided RU-486 Abigail Lowther, MD

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

Date 4/18/18

Send completed forms to:

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

MEDICAL BOARD
APR [illegible] 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: March 19 2018
   Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
   Founder's Women's Health Center

3. Address of medical practice or facility at which RU-486 was provided:
   1243 E. Broad St. Columbus, Ohio 43205

4. Date post RU-486 complication began:
   4.2.18

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: 01 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Harley Blank MD

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

Date 4/2/18

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 ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 10 (Month) 30 (Day) 2018 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Founders Women's Health Center.

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad Street Columbus, Ohio 43205

4. Date post RU-486 complication began:
11/14/18

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 abortion

6. Duration of event: ____ Hours 15 Days

7. Remarks: Patient was sent to Womens Med Center on 11/15/18 for a surgical abortion in Dayton, Ohio

8. a. Name of physician who provided RU-486 Karl Schaeffer, MD

8. b. Physician's signature Karl D. Schaeffer, M (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

MEDICAL BOARD

NOV 30 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: 5 - 7 - 18 (Month / Day / Year)

2. Name of medical practice or facility at which RU-486 was provided:
Founders Womens Health ~~Clinic~~ Center

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St Columbus, Ohio 43205

4. Date post RU-486 complication began:
6 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: 0.1 Hours ____ Days

7. Remarks: 9mm vacuette D+C

8. a. Name of physician who provided RU-486 Harley Blank MD

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

Date 6 6 18

Send completed forms to:

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

MEDICAL BOARD
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: MARCH (Month) 13 (Day) 2018 (Year)

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

Founder's Women's Health Center

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

1243 E Broad St, Columbus OH 43205

4. Date post RU-486 complication began:

March 30, 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: 2.5 Hours _____ Days

7. Remarks:

Incomplete medication abortion. Confirmed by ultrasound
D and C performed, no complications. Pt tolerated well.

8. a. Name of physician who provided RU-486 Kara Schaeffer, MD

8. b. Physician's signature Kara Schaeffer M.D/D.O

Date 3-30-18

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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