(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	08	02	2018	
	Month	Day	Year	
2. Name of medical practice or facility at which f	RU-486 was pro	vided:	and the state of t	
Founders Womens Hea	1th(ent	er		
3. Address of medical practice or facility at	which RU-48	6 was provided:		
1243 & BROAD ST	Col	umbus O	hio 43205	
4. Date post RU-486 complication began:				
5. Event(s) (Please check all that apply):				
	reaction to RU-48	5 Patient hospital	ized	
and the state of t		জন্মকার ২ চুমুক্ত চুক্তর করিব ব র্ চিকিট্র ব		
Patient received a transfusion Severe bleeding				
Other serious event (specify)				
6. Duration of event: 20+/Hours Ø	Days			
7. Remarks:	•			
V. Vehiques:	•		•	
		1		
8. a. Name of physician who provided RU-	485 Hay	tey Blank_mo		
8. b. Physician's signature	MBLL		M.D/D.O	
	Date 3	16-18		
Send completed forms to:	Chaha h A = 11	cal Roard of Ohio		

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	9 Month		0	2018	
Name of medical practice or facility at wh		ovided:		1541	
The Founder's h			Cent	ч	
3. Address of medical practice or facilit	y at which RU-4	86 was provided:			
1243 E. Broad St	reet	Columbus	,040	43205	
4. Date post RU-486 complication bega	n:				
5. Event(s) (Please check all that apply)					
Incomplete abortionAdv	erse reaction to RU-4	36 Patient hosp	pitalized		
Patient received a transfusion Severe blee	ding			-	
Other serious event (specify)	iled Ab	ortion, f	etal d	<u>emrc</u> 6	
6. Duration of event: Hours	S Days				
7. Remarks: Patrent had t	Tailed ab	ortion o	end is	was sect t	10
The Women's Hed			_		
suggest about	ou ou	10/22/18	ر		
8. a. Name of physician who provided I	RU-486	lari I.	Schae	Her, wid	
8. b. Physician's signature	all S	chae/fer	<u></u>	.o.o	
	Date((-14-18			
Send completed forms to:	State Med	ical Board of Ohi	0		

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Columbus, OH 43215-6127

MEDICAL BOARD

NOV 1 9 20th

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	29	ير Day	2018	
			Year	
2. Name of medical practice or facility at which				
The Foundar's Wa	men's tte	PALTH (e	utes	
3. Address of medical practice or facility a	t which RU-486 \	was provided:		
1243 E Broad.	Street	Columbi	's, Olio 43205	
4. Date post RU-486 complication began: /O − ₽	-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)	iled Abo	ortion		
6. Duration of event: Hours _26	Days			
7. Remarks:				
Patient wasse	ut to	Women's	Men (euter	ia
Dayton, Ohio			77-5	·4.
8. a. Name of physician who provided RU-	486 <u>Kav</u>	of I. Sch	atter, und	
8. b. Physician's signature <u>(a</u>	Date 11-	ceffer		
Send completed forms to:				

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MEDICAL BOARD

WIN 13 MIN

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

531.18	Month Day Year
2. Name of medical practice or facility at w Founder's Womeno	thich RU-486 was provided: Health Center
3. Address of medical practice or facil	allity at which RU-486 was provided: Ad St. Columbus, Olic 432
4. Date post RU-486 complication be	gan:
5. Event(s) (Please check all that apple	Adverse reaction to RU-486Patient hospitalized
6. Duration of event: Ol Hours	Days
7. Remarks:	
	ed RU-486 Red Harky Blank mD

Send completed forms to:

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(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	May 21 2018 Month Day Year
2. Name of medical practice or facility at Founder's Wor	which RU-486 was provided: news Health Centu
3. Address of medical practice or fac	St. Columbus Ohio 43205.
4. Date post RU-486 complication be	egan:
S. Event(s) (Please check all that application) Patient received a transfusion Other serious event (specify)	Adverse reaction to RU-486Patient hospitalized
6. Duration of event: O·/Hours	Days
7. Remarks:	•
8. a. Name of physician who provid 8. b. Physician's signature	Date 6:18:18
Send completed forms to:	State Medical Board of Ohio

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Columbus, OH 43215-6127

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

	, 1 ore hill	SIGEN Who provided by the	_	
1. Date RU-486 was provided:		sician who provided RU-48	5	
was provided:				
	3_	28	10	
2. Name of modical - ::	Month	Day	18	
2. Name of medical practice or facility at	which RU-486 was	May	Year	
Fairmdian	was provid	ed:		
Founder's Women's Her	ieth Center			,
	The second secon			
3. Address of medical practice or fac				
or factice or fac	lity at which RU-486			
1242 8 2		so hlovideq:		
1243 8. Brosa St. , C	Edumber ali	7 3 4 5		
		2007		•
4. Date post RU-486 complication beg		•		
(1) Too complication beg	gan:		W	
7111/18			·	
. Event(s) (Please H				
. Event(s) (Please check all that apply) :			
y		:		
Incomplete abortion	h			
	iverse reaction to RU-486	Davissa		
	क कार्य व्यक्ति	Patient hospitalized		
Dations				
Patient received a transfusion Severe ble	adia			
	77.15			
				
Other serious event (specify)				
	- Wangston - Andrews			*
Duration of average				
Duration of event: O . I Hours	Dave			
	_ =0/3			
Remarks:				
	•			
Gestunctial sac visialization Managed w/ D&C. Pt +	don uls 4-11.10			
Managed w/ Dac. pf	biene d		• .	
•	بالمان المانية.			
Nome				
a. Name of physician who provided RU	1-126			
	Abigail	buther, MD		
). Physician's signature				
signature X	4	\sim		
1		(M.D)D.O	
	Date	8/18	<i>y</i>	
		710		
completed forms to:				
	State Medical n			
	State Medical Board	of Ohio		
MEDICAL BOADD Legal	Department			
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AFT # 6 2018

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Columbus, OH 43215-6127

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: B Murch 19 2018 Month Day Year	•
2. Name of medical practice or facility at which RU-486 was provided: Foundles-'s Women's Health Center	
3. Address of medical practice or facility at which RU-486 was provided: 1343 E. Brand St. Columbus, Ohio 43205	
4. Date post RU-486 complication began:	*****
5. Event(s) (Please check all that apply): Incomplete abortionAdverse reaction to RU-486Patient hospitalized Patient received a transfusionSevere bleeding	
Other serious event (specify) 6. Duration of event: Hours Days	
7. Remarks:	
8. a. Name of physician who provided RU-486 8. b. Physician's signature Date Date	
end completed forms to: State Medical Board of Ohio	

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

I. Date RU-486 was provided:	10	30	2018	
	Month	Day	Year	
2. Name of medical practice or facility at w				
Founder's Women	ir Health	Center.		
3. Address of medical practice or facili 1243 E. Broad で	ity at which RU-486 freet (0	was provided: (vubvs, (9612 4320S	
4. Date post RU-486 complication beg ` ししんけんしゃ	an:			
5. Event(s) (Please check all that apply) :			
Incomplete abortionAc	iverse reaction to RU-486	Patient hospitalize	d d	
Patient received a transfusion Severe ble	eeding	3. 1		
Other serious event (specify)	ailed abo	rtion		
6. Duration of event: Hours	i≤ _{Days}			
7. Remarks: Patient was	s sent to a surgical	Woodens	Meil Center	on 410
8. a. Name of physician who provided	1RU-486 <u>Ka</u>	N/ Schae	ffer, mb	
8. b. Physician's signature	1(a(),5 Date		Ŀ	
end completed forms to:	State Medica	l Board of Ohio		

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

NOV 3 U 2018

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	Month Day Year
2. Name of medical practice or facility a Founder's Won	which RU-486 was provided: Nens Health Clin Center
	cility at which RU-486 was provided: Strond St Columbous, Ohio 432015
4. Date post RU-486 complication to	egan:
5. Event(s) (Please check all that ap	ply): _Adverse reaction to RU-486Patient hospitalized
Patient received a transfusion Seven Other serious event (specify)	bleeding
6. Duration of event: <u>0.1</u> Hours	Days
7. Remarks: 9 mm va	curette DrC.
8. a. Name of physician who provides 8. b. Physician's signature	ed RU-486 Hartey Blank m.D. Date V. 15
Send completed forms to:	State Medical Board of Ohio
	Legal Department
	30 E. Broad St., 3 rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

: 1019

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	MARCH Month	いろ Dav	ao 18 Year
2. Name of medical practice or facility at wh	hich RU-486 was provided		
Founder's Woman's Heav	leth Center	•	
3. Address of medical practice or facility	ty at which RU-486 wa	s provided:	
1243 & Broad St, Colu	mbus 0H 433	05	
4. Date post RU-486 complication bega March 30, 2018	an:		
5. Event(s) (Please check all that apply):	•	
Incomplete abortionAd	verse reaction to RU-486 _	Patient hospitalized	
Patient received a transfusionSevere blee	eding		
Other serious event (specify)			
6. Duration of event: <u>2.5</u> Hours	Days	Takan III	
7. Remarks:	*		d
boot performed,			
8. a. Name of physician who provided	RU-486 <u>Kare</u>	Schaeffer, 1	MD
8. a. Name of physician who provided	RU-486 <u>Kare</u> (al Schae Date 3-30		

Sena completea forms to:

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