

(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	11		1.1
	Month	Day	Year
2. Name of medical practice or facility Planned Parenthoo	y at which RU-486 was provid L	led:	
3. Address of medical practice or facili	ity at which RII-486 was prov	idadı	
2314 Auburn Au			
4. Date post RU-486 complication beg	an:		
5. Event(s) (Please check all that apply) :		
Incomplete abortion	Adverse reaction to RU-486	Patient hospitalized	i
Patient received a transfusion 🔑 Severe	e bleeding		
Other serious event (specify)			
. Duration of event: 2 Hours	5 Days		
. Remarks:			
٠,			
a. Name of physician who provided F	N. 1.2		
	do ii	Kalsm.	
b. Physician's signature	Date 11/15/18	(M.D.//I	<u> </u>
and completed forms to: Sta	te Medical Board of Ohio		
Legal Depa		or F	The British
	i St., 3 rd Floor		MOV) (313
Columbus.	OH 43215-6127		211



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was prov	ided:	10	25	. 0
		Month	Day	Year
2. Name of medical pract Planned Par	ice or facility at which	RU-486 was provide	ed:	теат
3. Address of medical prac	tice or facility at which	h PII 495		
2314 Aubur				
4. Date post RU-486 comp				
5. Event(s) (Please check a	I that apply):			
Incomplete abortion	Adverse r	eaction to RU-486	_ Patient hospitalize	ed .
Patient received a transfusic	nSevere bleeding			
Cother serious event (specify)	Faile h	nd As		
5. Duration of event:	Hours	Days		
Remarks: Completed	Surgically			
a. Name of physician who	provided RU-486	Dr.	Kelnin	
b. Physician's signature	- lin	lin		
	Date	11/1/18	- MD//	D.G.
nd completed forms to:	State Medical	Board of Ohio		
	Legal Department	50 10 10 10 10 10 10 10 10 10 10 10 10 10	•	
	30 E. Broad St., 3 rd Flo	or		
	Columbus, OH 43215			in the state of th
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(Required pursuant to R.C. 2919,123)

1. Date RU-486 was provided:	/0	17	
	Month	Dav	18
2. Name of medical practice or facility Planned Parenthood	at which RU-486 was provi	ded:	Year
3. Address of medical practice or facility 2314 Auburn Aue.	at which RU-486 was prov	rided: 45219	
4. Date post RU-486 complication began	:: 7/9		
5. Event(s) (Please check all that apply):			
Incomplete abortion	Adverse reaction to RU-486	Patient hospitalized	ı
Patient received a transfusion Severe b	leeding		
COther serious event (specify)Fail	il St.		*****
Duration of event: Hours	2 Days trent.	num tim	
Remarks: Completed Surgice			
a. Name of physician who provided RU	-486	V !	
b. Physician's signature	Vilaly Date 2/15/1	Koin (MO)/O	.0
nd completed forms to: State	Medical Board of Ohio		
Legal Departr			
30 E. Broad St	t., 3 rd Floor		
Columbus, Of	d 43215-6127		



(Required pursuant to R.C. 2919,123)

1. Date RU-486 was pro	vided:	10	4	, 9
	·	Month	Day	Year
2. Name of medical prac Planned Pa	tice or facility at which RU	-486 was provid	ed:	i edi
3. Address of medical pra	actice or facility at which RI	LASS was provide		
	n Au. Una			
4. Date post RU-486 com				
5. Event(s) (Please check				
	S, HAdverse react	tion to RU-486	Patient hospitaliz	ed
Patient received a transfus				
Other serious event (specif	y)			
. Duration of event:	Hours Do	ays		
P. Remarks:	medication.			
a. Name of physician wh	o provided RU-486	Je Kol		
b. Physician's signature	- Mali	7	MOI	DO
	Date		18	
nd completed forms to:	State Medical Box	ard of Ohio		
	Legal Department			MET
	30 E. Broad St., 3 rd Floor			METICAL ROAD
	Columbus, OH 43215-61	27		NOV 8 1 111



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	8	8	18
	Month	Day	Year
2. Name of medical practice or facility Planned Parenthoo		îded:	
3. Address of medical practice or facil	ity at which RU-486 was pro	ovided:	
2314 Auburn Au		7.34	
4. Date post RU-486 complication beg	an:	and the state of t	- Caracida de la Caracida de Caracida de
5. Event(s) (Please check all that apply)):	The state of the s	
Incomplete abortion	Adverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Sever	e bleeding		
QOther serious event (specify)Fa.	Ild medication	a Gbortian	
6. Duration of event:2_Hour	rs Days		
7. Remarks: Completed Sur	g rally.		
8. a. Name of physician who provided	DILAGO	Chileit	
8. b. Physician's signature	Date Date	29/1j W 101	0
Send completed forms to: St	ate Medical Board of Ohio		
Legal Dep	artment		
30 E. Broa	d St., 3 rd Floor	MEDI	CAL BOARD
Columbus	, OH 43215-6127	SI	EF 0 4 2018



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	8	2	18
	Month	Day	Year
2. Name of medical practice or facil	ity at which RU-486 was provi 2009 Southurs	ded:	
LANKA PONTO	ood Jouthwest	1 Ohio	tision
3. Address of medical practice or fac			0
2314 Auburn A	be.		
4. Date post RU-486 complication be $8/16/18$	gan:		
5. Event(s) (Please check all that appl	ly):		
Lincomplete abortion possible	Adverse reaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion Seve	ere bleeding		
Other serious event (specify)			
6. Duration of event: Hou	irs <u>30</u> Days (p+ n	nonitored e	our this time)
7. Remarks: Resolved w/miclinal	man e gemento		
. a. Name of physician who provided	RU-486 1 2	a. lata	
. b. Physician's signature	Malin	71	òa
	Date		
end completed forms to:	tate Medical Board of Ohio		
Legal Dep			
30 E. Bro	ad St., 3 rd Floor		****
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Columbus, OH 43215-6127



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	_6	4	18
2. Name of medical practice or facility at well anned Parenthood	Month hich RU-486 was prov	Day vided:	Year
3. Address of medical practice or facility at 2314 Auburn Au.			
4. Date post RU-486 complication began: 6/2/// り			
5. Event(s) (Please check all that apply):			
Pincomplete abortion p:35 i blcAd	verse reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe bleed	ding		
Other serious event (specify)			
6. Duration of event: 2 PNS for Hours	nem que well	fring.	
7. Remarks:			
			9
. •			
. a. Name of physician who provided RU-48	36 <u>D</u> r	· Kalon	
. b. Physician's signature	ally	MOU	0.0
	Date 1/29	/18	
end completed forms to: State Me	edical Board of Ohio		
Legal Departme	ent	3 (77)	
30 E. Broad \$t.,	3 rd Floor	MEI	DICAL BOARD
Columbus, OH	43215-6127		SEP 0 4 2018



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	4	28	18
	Month	Day	Year
2. Name of medical practice or facility at a Planned Parenthood	which RU-486 was provid	ed:	
3. Address of medical practice or facility at	which RU-486 was prov	ded:	
2314 Auburn Aus.			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
A	dverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe ble	eding		
Other serious event (specify)			······································
6. Duration of event:3Hours	Days		
7. Remarks: completed surpiculty	·		
8. a. Name of physician who provided RU-	486 . /)(Kiby	
8. b. Physician's signature	Maly		
or or regardan a aignature	_	(MD/DC	1
	Date —		
	Medical Board of Ohio		
Legal Departn		- •	BOARD
30 E. Broad St	•		L BOARD
Columbus, Of	ł 43215-6127		2018



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	_4	19	, 0
	Month	Day	Year
2. Name of medical practice or facility Planned Parenthood	vat which RU-486 was provi	ded:	
3. Address of medical practice or facilit	ty at which RU-486 was prov	ilded:	
2314 Auburn Au			
4. Date post RU-486 complication bega レクルド			
5. Event(s) (Please check all that apply)	•		
Procomplete abortion	Adverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe	bleeding		
Other serious event (specify)			
5. Duration of event: 4 Hours	trectment timeDays		
7. Remarks: Completed Surgical	lly		
.a. Name of physician who provided Ri	11-486	- Y. 16	
. b. Physician's signature	Miller, Date 7/18	18 MD 100)
end completed forms to: State	e Medical Board of Ohio		
Legal Depar	· ·		
	St., 3 rd Floor		
	OH 43215-6127	MEDIO	CALBOARD

JUL 23 2018



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was pro	vided:	_ 3	28	; {
		Month	Day	Year
2. Name of medical pra Plannid Pa	ctice or facility at which Ri MNH00L	J-486 was prov	ded:	
3. Address of medical pra	actice or facility at which F	211-486 was pro	italo at.	
	n Aue. and	a, OH	45219	
4. Date post RU-486 com	plication began: 식/	3118		
5. Event(s) (Please check	all that apply):			
Ancomplete abortion				
श्रीताच्या । १००० वर्षः स्थापन्यः <mark>स्थापन्यः स्थापन्यः ।</mark>	Adverse rea	ction to RU-486	Patient hospitalized	
Patient received a transfus	ion Levere bleeding			
	- -			
Other serious event (specif	ý)			
. Duration of event:	Hours	Davs +		
The second secon		776	men NIK	
. Remarks:				
	•			
a. Name of physician wh	o provided RU-486	1)_	1.6	
b. Physician's signature	114	Dr. 1664	1007	
		14/41	MD/D	
nd			10	
nd completed forms to:	State Medical Bo	oard of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd Floor			nen
	Columbus, OH 43215-6:	127	-510	AL BOAR!! R 1 2 2018
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ribed: 5//2011, Rev. 12/13/12			NPI	K 1 " "



(Required pursuant to R.C. 2919,123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	2	2:	_
- Sare no labo was browded.	 Month	2.6	
2. Name of medical practice or facility at Planned Parenthood	which RU-486 was provi	Day ded:	Year
3. Address of medical practice or facility a 2314 Auburn Au.			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
	Adverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe bl	eeding		
Other serious event (specify)			
6. Duration of event: Hours _	Days		
7. Remarks: (150hd w/ 200	don of miso,	02540/	
8. a. Name of physician who provided, RU	-486 <i>(</i>)/	- Kily	
	Date 5/14/	MO)O	2
Send completed forms to: State	Medical Board of Ohio		
Legai Depart	ment		
30 E. Broad S	it., 3 rd Floor	MEDIC	AL BOARD
Columbus, O	H 43215-6127		
		MAY	2 1 2018

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



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provid	led:	_3	15	18
2. Name of medical practice Planned Pare	e or facility at which	Month h RU-486 was provid	Day ed:	Year
3. Address of medical practical and an arrangement of the second	Aur. (1) ration began; (notifical rhat apply): —Adverse r	th RU-486 was provided on the control of the contro	45219	
Other serious event (specify) Duration of event:		Days		
Remarks: informed by pt. Uswhere and			hid bu	n gen
. Name of physician who pro	Dided RU-486 Date	-) \&/ ly 4/18/18	M.D. / D.C	
		11/1/		

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



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	_ 2	24	18
	Month	Day	Year
2. Name of medical practice or facility at Planned Parenthood	which RU-486 was provi	ded:	
3. Address of medical practice or facility at			
2314 Auburn Aue.	ana, of	45219	
4. Date post RU-486 complication began: 3 テノバア			
Discomplete abortion Failed Ad	verse reaction to RU-486	Patient hospitalized	3
. Duration of event: 2 Hours	Days		
Remarks: Completed Surpicely			
a. Name of physician who provided RU-48	36 h D.	Keling	
b. Physician's signature	fMalan Date 3/14/	18 Mb 10	10
nd completed forms to: State Me	edical Board of Ohio		

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

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(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:		24	,0
	Month	Day	Year
2. Name of medical practice or facility Planned Parenthood	at which RU-486 was provic	led:	160
3. Address of medical practice or facility	at which RU-486 was prov	ded:	
2314 Auburn Aug.	ana, of	45219	
4. Date post RU-486 complication began $2l_1 \psi l_1 \%$			
5. Event(s) (Please check all that apply):			
√ Incomplete abortion	Adverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe b	pleeding		
Other serious event (specify)			
Duration of event: Hours	Days		
. Remarks:			
a. Name of physician who provided RU	-196 A E		
b. Physician's signature	Maly	2	
	Date 2/21	LIP. MOHOL	1
nd completed forms to: State	Medical Board of Ohio		
Legal Depart		M	DICALL MAR
30 E. Broad S	t., 3 rd Floor		
Columbus O	H 42715-6127		FEB 2 G (1-13