

(Required pursuant to R.C. 2919.123)

1. Date RU-486 was pro	ovided:	12	27	10
		Month	Day	Year
2. Name of medical pra Planned Pa	ctice or facility at which RU	-486 was provid	ed:	, CGP
3. Address of medical pr	actice or facility at which R			
2314 Aubu	n Au. and	i, oH	45219	
4. Date post RU-486 com				
. Event(s) (Please check	all that apply):			
and the state of t				1
Incomplete abortion	Adverse reac	tion to RU-486	_ Patient hospitalize	ed
Patient residual assured	•			
Patient received a transfu	sion Severe bleeding	•		
	N) Failed me			
Duration of event:	2 for treatment D	əys		
. Remarks:				
	Surprally			· · · · · · · · · · · · · · · · · · ·
	i			
a. Name of physician wh	o provided RU-486		1	The state of the s
b. Physician's signature	B	-	con p	N.
or i masician a signature			M.O./	0.0
	Date —	1/16	19	
nd completed forms to:	State Medical Box	ard of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd Floor		ME	EDICAL BOARD
	Columbus, OH 43215-61	7 7		JAN 2 8 2019
		~ /		(1) (1) # 왕 왕 5.81 (1)



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	PO	31	18
	Month	Day	Year
2. Name of medical practice or facility at Planned Parenthool	which RU-486 was provid	ed:	166
3. Address of medical practice or facility at 2314 Auburn Au.			
4. Date post RU-486 complication began:	in an in ing an dip romoning pama T		
5. Event(s) (Please check all that apply):			
incomplete abortionAc	dverse reaction to RU-486	Patient hospitalized	· !
Patient received a transfusion Severe blee	eding		
Other serious event (specify)	I med the		
6. Duration of event: Hours	2 for tw.		
7. Remarks:	ally	,	
. a. Name of physician who provided RU-4	86	o. biel	
. b. Physician's signature	Date = 2/14/A	(MD)/C	10
end completed forms to: State N	ledical Board of Ohio		
Legal Departme			
30 E. Broad St.,	3 rd Floor		
Columbus, OH	43015.6107		



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	9	26	, 1
	Month	Day	/ <i>J</i>
2. Name of medical practice or facility Planned Parenthoo	at which RU-486 was prov	ided:	1001
3. Address of medical practice or facilit	v at which RU-486 was pro	vidad:	
2314 Auburn Au			
4. Date post RU-486 complication bega	A CONTROL OF CONTROL O		
5. Event(s) (Please check all that apply)	7.77.711		
Incomplete abortion (Fix last)		Patient hospitalized	ſ
Patient received a transfusion Severe	bleeding		
Other serious event (specify)			
Duration of event: Hours	Days		
	utul so jul	lu·	
	0 .00		
a. Name of physician who provided Ri	J-486	ling	
b. Physician's signature	5.	4810	
	Date	16/18	L <u>Q</u>
nd completed forms to: State	Medical Board of Ohio		
Legal Depar			
	St., 3 rd Floor		•

Columbus, OH 43215-6127

MEDICAL BOARD

Prescribed: \$/--/2011, Rev. 12/13/12

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

To be completed by the physician who provided RU-486

	rovided:	D	00	1.2
		Month	2 2	
2. Name of medical pro-	actice or facility at which	h RU-486 was pr	ovided:	Year
3. Address of medical p	ractice or facility at whi			
2314 Aubu	on Aur. G	na oH	rovided: 45219	
I. Date post RU-486 con	mplication began:			
. Event(s) (Please check	(all that apply):			
Incomplete abortion		reaction to RU-486	Patient hospitalized	
_ Patient received a transfu				
Other serious event (speci	ity) Fail14	1 medica	to abotio	7
		11400-Ca	- Jun 6.80 110	
Duration of event:				
Duration of event:		Days		
Duration of event:Remarks:	2 Hours	Days		
Duration of event: Remarks: Complete Name of physician wh	2 Hours	Days		
Duration of event:Remarks:	2 Hours	Days	lint:	
Duration of event: Remarks: Complete Name of physician wh	2 Hours	_Days		
Duration of event: Remarks: Complete Name of physician wh	2 Hours	_Days w/o incid	Par lin!	
Duration of event: Remarks: Complete Complete Name of physician wh Physician's signature	2 Hours I Sury (ally to provided RU-486 Date State Medical	_Days	Par lin!	
Duration of event: Remarks: Complete Complete Name of physician wh Physician's signature	2 Hours	Days W/o incid 9/	Par lin!	

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



Prescribed: \$/--/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-485

1. Date RU-486 was provided:		<u></u>	16	18
2. Name of medical practice or Planned Parent	facility at which	Month RU-486 was provi	Day ded:	Year
3. Address of medical practice o	r facility at which	RU-486 was prov	/ided:	
2314 Auburn	Ave. ar	ia, of	45219	
4. Date post RU-486 complicatio				
5. Event(s) (Please check all that				
Incomplete abortion	Adverse re	eaction to RU-486	Patient hospitalized	d d
Patient received a transfusion 🗡	Severe bleeding			
Other serious event (specify)				- Company
6. Duration of event:	Hours	Days NIA		
7. Remarks: Significant dead treatment	core in Tho		ouvo, pt. s	table y ps
. a. Name of physician who provi	ded RU-486	_ 0- 0	4-1	
. b. Physician's signature	Date .	9/15718	WR TI	0.0
end completed forms to:	State Medical			
	Department	DONG OF UNIO		
	Broad St., 3 rd Flo	or		
	nbus, OH 43215		MEDIC	AL 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)

1. Date RU-486 was prov	ided:	8	15	18
		Month	Day	Year
2. Name of medical pract Planned Pace	ice or facility at which RI Enthood	J-486 was provi	ded:	
3. Address of medical prac	tice or facility at which F	RU-486 was prov	ided:	
' .	n Au. Una			
4. Date post RU-486 comp	lication began:			
5. Event(s) (Please check a	II that apply):			
Incomplete abortion	Adverse rea	ction to RU-486	Patient hospitalized	
Patient received a transfusi	on \(\begin{align*} \text{Severe bleeding} \)			
Other serious event (specify	n)	·		<u>-</u>
6. Duration of event:	3_Hours	Days		
7. Remarks:				
O a Name of the state of	•.		, , , , , , , , , , , , , , , , , , , 	
8. a. Name of physician wh	o provided RU-486		nolin	
8. b. Physician's signature		0/2	\$/19	-
	Date —	1/20	1// /	
send completed forms to:	State Medical E	Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd Floo		MEDICAL BOA	RD
	Columbus, OH 43215-	6127		
			AUG \$ 1 2018	



(Required pursuant to R.C. 2919.123)

	11		
1. Date RU-486 was provided:		12	18
	Month	Day	Year
2. Name of medical practice or facility at	which RU-486 was provid	led:	
Planned Parenthood	South West 1	nio	
3. Address of medical practice or facility a	t which RU-486 was prov	ided:	
2314 Aubon Aus.	ananati.	OH 452	19
2314 Aubra Avr. 4. Date post RU-486 complication began:	7/16/18		
5. Event(s) (Please check all that apply):			
<u>V</u> Incomplete abortion	Adverse reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe bl	eeding		
Other serious event (specify)			
6. Duration of event: Hours _	Days	· · · · · · · · · · · · · · · · · · ·	
7. Remarks:			
ν.			
8. a. Name of physician who provided RU	1-486 <u>Dr. Lin</u>	,/	
8. b. Physician's signature	<u></u>	M.D.,	/0.0
	Date	118	
Send completed forms to: State	e Medical Board of Ohio		
Legal Depar	tment		MEDICAL BOA
30 E. Broad	St., 3 rd Floor		MEDIO, -
Columbus, (DH 43215-6127		JUL 3 1 250



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided	:	7	11	18
		Month	Day	Year
2. Name of medical practice of Planned Parkn		RU-486 was provid	ed:	and the same of th
3. Address of medical practice	or facility at which	h RU-486 was provi	ded:	
2314 Auburn			The first section of the section of	
4. Date post RU-486 complicat	ion began: 7/	18/18		The state of the s
5. Event(s) (Please check all th	The second secon		Talvar (a seria, j	
Incomplete abortion	Adverse	reaction to RU-486	Patient hospitali	ized
Patient received a transfusion	Severe bleeding			
Other serious event (specify)	anguing	bullow	y	
6. Duration of event:	Hours	Days		
7. Remarks: furgical abor	tion der			
3. a. Name of physician who pr	ovided RU-486	,	Kests 4	orr line
8. b. Physician's signature	Date		,	/0.0
Send completed forms to:	State Medic	al Board of Ohio		
Le	gal Department		,	MEDICAL BOAR
30	E. Broad St., 3 rd F	loor	·	MEDICAL BOAR
Co	olumbus, OH 4321	15-6127		•



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provid	led:	4	1(18
		Month	Day	Year
2. Name of medical practic		I-486 was provid	led:	
3. Address of medical pract	tice or facility at which R	U-486 was prov	ided:	
2314 Auburr				
4. Date post RU-486 compl	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1		The plant of the second of	•
5. Event(s) (Please check al	/ that apply):			
Incomplete abortion	Adverse rea	ction to RU-486	Patient hospitalized	
Patient received a transfusio	n & Severe bleeding			
Other serious event (specify)				
6. Duration of event:	Hours	Days		
7. Remarks: pt. Stuble,	staged on , vo	-		
	· .	•	7.00	
3. a. Name of physician who	provided RU-486		· bal	
3. b. Physician's signature	Date -	5/1/18		
end completed forms to:	State Medical B	oard of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd Floo	r	MEDICAL	BOARD
	Columbus, OH 43215-6	5127	MAY 2	£ 2018

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



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provide	·d:	11		. 0
·			Day	Year
2. Name of medical practice	. //	RU-486 was prov	rided:	1001
3. Address of medical practic	e or facility at which	RU-486 was pro	ovided:	
2314 Auburn		,		
4. Date post RU-486 complic				
5. Event(s) (Please check all t	The state of the s			
Incomplete abortion	Adverse r	eaction to RU-486	Patient hospitalized	i
Patient received a transfusion	Severe bleeding			
Other serious event (specify)				
6. Duration of event:	/ +k/ Hours	_ Days		
7. Remarks: Trial of ma	licing but , the success.	rudul D.	C which we	s done
3. a. Name of physician who p	provided RU-486		ma line	
3. b. Physician's signature			M.D./1	2.0
	Date	110/	•	
end completed forms to:	State Medica	l Board of Ohio		
ı	egal Department			
;	30 E. Broad St., 3 rd Fl	oor	MEDICA	AL BOARD
(Columbus, OH 4321!	5-6127	MAY	2 1 2018



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

	ovided:	3	22	.0
	The state of the s	Month		
2. Name of medical pra	actice or facility at which i	RU-486 was provide	d:	Year
3. Address of medical nu	ractice or facility at which			
02 41 4 4	dedice of facility at Which	RU-486 was provide	ed:	
2319 Aubu	on Au. an	a of 4	15219	
. Date post RU-486 con	oplication began:	•		
Eventel (a)	4	15/18		
Event(s) (Please check	all that apply):			
Incomplete abortion	Adverse re	action to RU-486	Patient hospitalized	
_Patient received a transfu			Phone	
	and a second			
Other serious event (speci	fy)			
				_
Ouration of event:	2 Hours	Davs		
Remarks:				
	c - i . 1/2	-		
Completed				
Completed	July any			
	``````````````````````````````````````			
	``````````````````````````````````````	R	// 6	
Name of physician wh	``````````````````````````````````````	B.	Long	
Name of physician wh	o provided RU-486	B.	MD/00	
Name of physician who	o provided RU-486	B.		
Name of physician who	o provided RU-486		MD/DO	
Name of physician who	Date — State Medical Bo	pard of Ohio	MD/DO	ROARD
Completed Name of physician who Physician's signature completed forms to:	O provided RU-486 Date — State Medical Bo	pard of Ohio		BOARD



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was pro	ovided:			
		Month	<u> </u>	1 18
2. Name of medical pra Planned Pa	ctice or facility at which R		ed:	Year
	actice or facility at which			
4. Date post RU-486 com	plication began:			
Incomplete abortion		action to RU-486	Patient hospitalized	I
Patient received a transfus Other serious event (specif				
	Hours	Days		
Remarks: Resolved 4				
a. Name of physician wh	o provided RU-486		Dr. Gal	
b. Physician's signature	Date —	2/2.	/13 MD/D	0
nd completed forms to:	State Medical B	oard of Ohio		
	Legal Department		MET	MCAL DOMESTIC
	30 E. Broad St., 3 rd Floo		MET	DICAL BOARD
	Columbus, OH 43215-6	127	!	FEB 2 6 2016