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 [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: 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 48213

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. circled)/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

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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 [signature] (M.D.)/D.O (M.D. circled)

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: 6 5 (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 [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: 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 (MD circled)

Date 11/13/18

Send completed forms to:

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

MEDICAL BOARD
[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: 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: 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, ~~tx~~ TREATED W/ASPIRATION

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

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

Date 11/27/18

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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