

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:	<u>01</u> Month	<u>26</u> Day	<u>2018</u> Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Capital Care Network Toledo</u>		
3. Address of medical practice or facility at which RU-486 was provided:	<u>1160 W. Sylvan Ave. Toledo, OH 43612</u>		
4. Date post RU-486 complication began:	<u>02/20/2018</u>		
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event:	<u>4</u> Hours <u>0</u> Days		
7. Remarks:	<u>Incomplete med. AB. D&C completed. No complications</u>		
8. a. Name of physician who provided RU-486	<u>Dr. L. Ann Nunnally</u>		
8. b. Physician's signature	<u>L. Ann Nunnally MD</u>	<u>M.D./D.O.</u>	
	Date	<u>02/20/2018</u>	

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

APR 13 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: 04 27 2018
Month Day Year

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

3. Address of medical practice or facility at which RU-486 was provided:
1160 W. Sylvan Ave.

4. Date post RU-486 complication began:
06-02-18

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) _____

6. Duration of event: 5 Hours _____ Days

7. Remarks: Incomplete med ab. pt requests d/c.
D/c completed. 2 complications
WIK0819

8. a. Name of physician who provided RU-486 _____
8. b. Physician's signature L. A. Mally MD (M.D./D.O. _____)
Date 06/02/18

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MEDICAL BOARD
JUN 11 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:	05 Month	10 Day	2018 Year
2. Name of medical practice or facility at which RU-486 was provided:	Capital Care Network Toledo		
3. Address of medical practice or facility at which RU-486 was provided:	1160 W. Sylvania Ave Toledo OH 43612		
4. Date post RU-486 complication began:	05/23/2018		
5. Event(s) (Please check all that apply):	<input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed Medical Abortion</u>		
6. Duration of event:	___ Hours <u>2</u> Days		
7. Remarks:	Surgical abortion completed on 05/25/2018. GUK0730		
8. a. Name of physician who provided RU-486	Dr. Lucy Ann Nunnally		
8. b. Physician's signature	<u>Lucy Ann Nunnally MD</u> (M.D./D.O.)		
	Date <u>5/25/18</u>		

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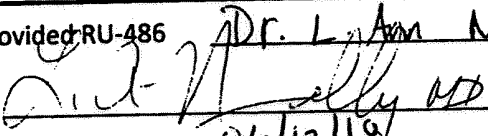
Columbus, OH 43215-6127

MEDICAL BOARD

JUN 11 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:	<u>05</u> Month	<u>07</u> Day	<u>18</u> Year
2. Name of medical practice or facility at which RU-486 was provided:	Capital Care Network of Toledo		
3. Address of medical practice or facility at which RU-486 was provided:	1160 W. Sylvania Ave. Toledo, OH 43612		
4. Date post RU-486 complication began:	06/12/18		
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event:	<u>2</u> Hours _____ Days		
7. Remarks:	Incomplete Med. AB . D+C complet. & complications NOA 0927		
8. a. Name of physician who provided RU-486	Dr. Lynn Nunnally		
8. b. Physician's signature	 (M.D./D.O.)		
	Date <u>06/12/18</u>		

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MEDICAL BOARD

JUN 26 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: 06 / 12 / 2018
Month Day Year

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

3. Address of medical practice or facility at which RU-486 was provided:
1160 W. Sylvania Ave. Toledo, OH 43612

4. Date post RU-486 complication began:
08-13-18

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) _____

6. Duration of event: _____ Hours 1 Days

7. Remarks: Incomplete medical abortion

8. a. Name of physician who provided RU-486: Dr. Lucy Ann Nunnally

8. b. Physician's signature: [Signature] MD
Date: 8/25/18 (M.D./D.O.)

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Legal Department
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MEDICAL BOARD

AUG 29 2018

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:	<u>2</u>	<u>9</u>	<u>18</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Northeast Ohio Women Center</u>		
3. Address of medical practice or facility at which RU-486 was provided:	<u>2127 State Rd Cumbria Falls, Ohio 44723</u>		
4. Date post RU-486 complication began:	<u>3/5/18</u>		
5. Event(s) (Please check all that apply):	<u>Failed</u>		
<input type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized	
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding		
<input type="checkbox"/> Other serious event (specify)	<u>Failed Medab</u>		
6. Duration of event:	_____ Hours	_____ Days	
7. Remarks:			
8. a. Name of physician who provided RU-486	<u>J. Ann Munnally, MD</u>		
8. b. Physician's signature	<u>[Signature]</u>		
	Date	<u>3/5/18</u>	<u>MD/DO</u>

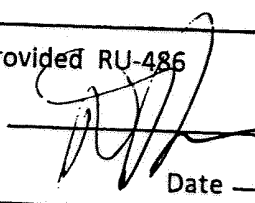
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MEDICAL REPORT

State Medical Board of Ohio Report of RU-486 Event

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To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	3	31	18
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	NORTHEAST OHIO WOMENS CENTER LLC 2127 STATE RD CUYAHOGA FALLS, OH 44223		
3. Address of medical practice or facility at which RU-486 was provided:	NORTHEAST OHIO WOMENS CENTER LLC 2127 STATE RD CUYAHOGA FALLS, OH 44223		
4. Date post RU-486 complication began:	4/14/18		
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event:	2	Hours	_____ Days
7. Remarks:	mostly int is small amt of vllh sample suction aspirator done & difficult		
8. a. Name of physician who provided RU-486	L. Ann Murnally		
8. b. Physician's signature			
	Date	4/14/18	MD / DO

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411 303