(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	13	26	2018	The state of the s
	Month	Day	Year	
2. Name of medical practice or facile Care W				
3. Address of medical practice of 1160 W. Sylvan Ka	or facility at which RU-486	was provided:		
4. Date post RU-486 complication ひる / みっ / ショ	on began:			
5. Event(s) (Please check all tha	t apply):			
ncomplete abortion	Adverse reaction to RU-486	Patient hospitaliz	ed	
Patient received a transfusion S	evere bleeding			
Other serious event (specify)			<del>ang managan managan pagama</del> n	
6. Duration of event: 4 Ho	urs <u>Ø</u> Days			
		α - L - L		
7. Remarks: jucuprete	Wed His. Dicc	cenyaten	. K conflictions	
8. a. Name of physician who pro	ovided RU-486	· L. Ann A	Junnally	
8. b. Physician's signature	Date <u>02</u>	4 MD 120/2018	M.D/D.O	
Send completed forms to:	State Medica	Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 <sup>rd</sup> Flo	oor iVI	EDICAL BUNKE	
	Columbus, OH 43215	-6127	APR 1.3 2018	

(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 provid	ed:		
Capital Core Wetwork.	of Tolecto			
3. Address of medical practice or fac	cility at which RU-486 v	vas provided:		
1140 W. Sylvania A	WE.			
4. Date post RU-486 complication be $00-02-19$	egan:			
5. Event(s) (Please check all that app	oly):			
X	4 p. 11 496	Patient hospitaliz	ad.	
Incomplete abortion	Adverse reaction to RU-486	Fatterit nospitanz		
Patient received a transfusionSevere	bleeding			
Other serious event (specify)				
			in the second	
6. Duration of event: Hours	Days			
7. Remarks: Incomplete M	ll ab. pt region	sts dtc.		
Suc consister	1.0 Computation	<b>.</b> \$		
Over son from	7		•	WIK0819
8. a. Name of physician who provid	ed RU-486	<del>\/</del>		
8. b. Physician's signature	the last	ly MD	(M.D/D.O	
a. b. rhysician s signature	Data Olal	7219		•
	Date <u>(i()</u>	me he		
end completed forms to:				

**State Medical Board of Ohio** 

**Legal Department** 

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

JUN 11 2018

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	05	10		2018	
	Month	Day		Year	
2. Name of medical practice or facility at v	which RU-486 was pro Ltwr K T	ovided: Tole do			
3. Address of medical practice or faci	lity at which RU-48	6 was provide	d:		
1160 W. Sylvania					N.
4. Date post RU-486 complication be 05   23   2 0	gan: 2				
5. Event(s) (Please check all that app	у):				
Incomplete abortion	dverse reaction to RU-48	6 Patient h	ospitalized		
Patient received a transfusion Severe b	leeding				
Other serious event (specify)	unled med	lical Ar	artin		:
6. Duration of event: Hours _	2_Days				
7. Remarks: Surgical ab	orthon coi	npieted	<b>3</b> 1		
05/25/2018		•			
					GUK0730
8. a. Name of physician who provide	( ) # I · ·	1111	Ann 1	Junail	4
8. b. Physician's signature	Date	lly MD 5/25/18	}(	M.D)D.O	_
Send completed forms to:	State Med	ical Board of C	)hio		

**Legal Department** 

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

JUN 11 2018

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	0.5	07 Day	18 Year	-
2. Name of medical practice or facility at which	7 - 1 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2			
Capital Core Wetwork			again a state of the state of t	
3. Address of medical practice or facility	at which RU-48	6 was provided:	2	
4. Date post RU-486 complication began 06/12/18				
5. Event(s) (Please check all that apply):				
Incomplete abortionAdve	rse reaction to RU-48	6 Patient hospita	lized	
Patient received a transfusion Severe bleed	ling			
Other serious event (specify)				
6. Duration of event: 2 Hours	Days			
7. Remarks: Incomplete Med	, AB . Dt	c complet.	1. of complicati	unl
			NOA 6	927
8. a. Name of physician who provided f 8. b. Physician's signature	0 Date 06	1177	Junaally M.d/D.O	

Send completed forms to:

State Medical Board of Ohio

**Legal Department** 

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD
JUN 2 6 2018

AUG 29 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:		who provided RU.	486	
	_06	12	000	
2. Name of medical practice or facility at v	Month	Day	2018 Year	
Cantal A	vnich RU-486 was provided:			
Capital Care he	work Totedo			
3. Address of medical practice and w				
3. Address of medical practice or facil	ty at which RU-486 was pr	rovided:		
	VE. Toledo, or	H 4361	2	
4 Dato mental				•
4. Date post RU-486 complication beg	n:			
09-12-18				
. Event(s) (Please check all that apply				
Incomplete abortion				
Adv	erse reaction to RU-486 Pat	lant base to		
	•	tient hospitalized		
Patient received a transfusionSevere blee	ding			
Other serious event (specify)				
Duration of				
Duration of event: Hours	Days			
Remarks: 11			•	
nemarks: Incomplete mus	lical almost			
	0000 0000			
			·	
	•			
a. Name of physician who provided Ro	186 a DC Luc			
	486 Dr. Lucy	Ann No	innally	
b. Physician's signature	-/ tolly MD	_		
	Date	Jackie (	1.by0.o	
	Jake	05/18		
completed forms to:				
	State Medical Board of	Ohio		
Legal	Department			
	Broad St., 3 <sup>rd</sup> Floor			
Colum	bus, OH 43215-6127	•		
			APDICAL BOAD	n
			MEDICAL BOAR	IJ

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	_2	Ś	18
	Month `	Day	Year
2. Name of medical practice or facility at Merthern (	which RU-486 was prov hen Momen	ided: 2 Centz	
3. Address of medical practice or facility a	twhich RU-486 was pro		
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):  - Call  Incomplete abortion			
Patient received a transfusion Severe ble Other serious event (specify)	dverse reaction to RU-486 eding	ratient nospitalized	
6. Duration of event: Hours	Days		
7. Remarks:			•
8. a. Name of physician who provided RU-8. b. Physician's signature	486 ) (Ls Date 3/5/8	n Muny	UlyMin)
Send completed forms to: State I	Medical Board of Ohio		, , ,
Legal Departn 30 E. Broad St		NEOK	AL ACAPT
Columbus, OF	į	V (2)	• •

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	3	31	10/
	Month	Day	
2. Name of medical practice or facility a		HEAST OHIO WOMENS OVIDED: LLC 2127 STATE RD UYAHOGA FALLS, OH 44	
3. Address of medical practice or facility	rat which Bu soc. No	HED-1	
3. Address of medical practice or facility	at Which RU-486 Was p	ELU	IS CENTER
		2127 STATE RD CUYAHOGA FALLS, OH	44223
4. Date post RU-486 complication began	llex		
5. Event(s) (Please check all that apply):	III.80		
Control on cliar apply).			
Incomplete abortion	Adverse reaction to RU-486	Dations house to	•
		r attent nospitalize	d .
Patient received a transfusion Severe b	leeding		
	•		
Other serious event (specify)			•
Duration of event: Hours _	Days		
Remarks: Mosly in	1 à small	end 1	101
Remarks: Mostly ula Simple Sustin a	40 7 1 I	MIN INV	a
sorgia ousun v.	gurne an	18 dilheul	
		7,	
a. Name of physician who provided RU-	486	Muna	_
b. Physician's signature	V//	Mumple	γ
January 5 Signature	1/	MD/i	20
	Date _ <u>4//4//</u>	/	
nd completed forms to: State	Medical Board of Ohio		
`` Legal Departr			
		NTDICK	L BOARD
30 E. Broad St		<i>i.</i> .	<u> </u>
Columbus, OF	43215-6127	in the second	ω · <b>ψ</b> 'ε'

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