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: 01 (Month) 26 (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:
02/20/2018

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: 4 Hours Ø Days

7. Remarks: Incomplete Med. Ab. D&C completed. K complications

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

8. b. Physician's signature L. A. Nunnally MD M.D/D.O

Date 02/20/2018

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 (Month) 27 (Day) 2018 (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.

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

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: 5 Hours _____ Days

7. Remarks: Incomplete med ab. pt requests d+c. D+C completed, ∅ complications

WFK0819

8. a. Name of physician who provided RU-486 ____________________

8. b. Physician's signature L. A. Nolly MD (M.D)/D.O ___

Date 06/02/18

Send 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

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):

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed Medical Abortion

6. Duration of event: _____ Hours 2 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 [signature] MD (M.D./D.O.)

Date 5/25/18

Send 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

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) 07 (Day) 18 (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):

✓ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) ______________________

6. Duration of event: 2 Hours _____ Days

7. Remarks: Incomplete Med. AB. D+C completed. ∅ complications

NOA 0927

8. a. Name of physician who provided RU-486 Dr. LeAnn Nunnally

8. b. Physician's signature [signature] MD (M.D)/D.O___

Date 06/12/18

Send completed forms to: State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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 (Month) 12 (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:
08-13-18

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 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: L. A. Nunnally MD

Date 8/25/18 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

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: 2 (Month) 5 (Day) 18 (Year)

2. Name of medical practice or facility at which RU-486 was provided: Northeast Ohio Women Center

3. Address of medical practice or facility at which RU-486 was provided: 2127 State Rd Cuyahoga Falls, Ohio 44223

4. Date post RU-486 complication began: 3/5/18

5. Event(s) (Please check all that apply):

Failed

___ ~~Incomplete~~ abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) Failed Medab

6. Duration of event: _____ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 L. Ann Mansfield MD

8. b. Physician's signature _____ MD/DO

Date 3/5/18

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

MEDICAL RCADS

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) 31 (Day) 18 (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):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) ______________________

6. Duration of event: 2 Hours ________ Days

7. Remarks: Mostly clot c small amt of villi Simple Suction aspiration done without difficulty

8. a. Name of physician who provided RU-486 L. Ann Munnelly

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

Date 4/14/18

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