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: Jan (Month) 22 (Day) 2018 (Year)

2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East Surgery Center

3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus OH 43213

3255 E. Main St.
Columbus OH 43213

4. Date post RU-486 complication began: 1/26

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: 2 Hours 0 Days

7. Remarks: uncomplicated Dilation: Suction

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 2/7/18

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

MEDICAL BOARD
FEB 12 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: January (Month) 29 (Day) 2018 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood East Surgery

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: 3/21/18

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:
uncomplicated D&E

8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature _____ MD/D.O

Date 3/29/18

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: 1 (Month) 30 (Day) 18 (Year)

2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East Surgery

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: 2/8/18

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 Catherine Romanos

8. b. Physician's signature _____ M.D./D.O

Date _____

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: Feb (Month) 19 (Day) 2018 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood East Surgery

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: 2/28/18

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 _____ Days

7. Remarks:
uncomplicated suction

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 3/8/18

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

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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: March 22 2018
   Month Day Year

2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East Surgery

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: 4/5/18

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

___ Incomplete abortion
___ Adverse reaction to RU-486
___ Patient hospitalized
___ Patient received a transfusion
___ Severe bleeding
N Other serious event (specify) failed abortion

6. Duration of event: _____ Hours _____ Days

7. Remarks:
   complicated suction

8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature [signature] MD/DO

Date 4/19/18

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

MEDICAL BOARD
APR 20 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: April (Month) 19 (Day) 2018 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood East Surgery

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:
4/24/18

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 _____ Days

7. Remarks:
Uncomplicated D&C

8. a. Name of physician who provided RU-486 Katherine Romanos

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

Date 5/2/18

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

MEDICAL BOARD
MAY [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: 12 (Month) 14 (Day) 18 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began:

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 medication abortion

6. Duration of event: ___1___ Hours _____ Days

7. Remarks:
uncomplicated dilation and suction

8. a. Name of physician who provided RU-486 Catherine Remanus, MD

8. b. Physician's signature [signature] MD/DO

Date 1/10/19

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

MEDICAL BOARD
JAN 22 2019

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