

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

		The state of the s	
Date RU-486 was provided:	_01	09	2020
	Month	Day	Year
2. Name of medical practice or facility Planned Parenthoo	6	ded:	
3. Address of medical practice or facil	ity at which RU-486 was pro	vided:	
2314 Auburn Au	1. ana, of	45219	
4. Date post RU-486 complication beg			
5. Event(s) (Please check all that apply	/):	· ·	
L'Incomplete abortion / Failed	Adverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Seve	re bleeding		
Other serious event (specify)			
6. Duration of event: 2 Hou	treatment rs Days		
7. Remarks:	The second secon		
8. a. Name of physician who provided	RU-486 Dr.	leaby	
8. b. Physician's signature	Date 1/20	laby MD/1	0.0
Send completed forms to: St	tate Medical Board of Ohio	L	MEDION
Legal Dep	partment		MEDICAL BOAF
30 E. Bro	ad St., 3 rd Floor		FEB 0 4 2020

Columbus, OH 43215-6127



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	1	9	2020
	Month	Day	Year
2. Name of medical practice or facility:		ded:	1201
3. Address of medical practice or facility	at which RU-486 was prov	ided:	
2314 Auburn Au.	ana, of	4.5219	
4. Date post RU-486 complication began	:		
5. Event(s) (Please check all that apply):			
Uncomplete abortion / Fa, Lil _	Adverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe b	leeding		
Other serious event (specify)			
5. Duration of event: 2 Hours	Days		
7. Remarks: Completed Sojico	My		
a. Name of physician who provided RU	-486 Dr.	Kulin	
. b. Physician's signature	Date 1/3	(10 W D)ID	10
end completed forms to: State	Medical Board of Ohio		MEDICAL BOAR

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	4	17	20
	Month	Day	Year
2. Name of medical practice or facility at w Planned Parenthood	rhich RU-486 was provid	ed:	
3. Address of medical practice or facility at	which RU-486 was provi	ded:	
2314 Auburn Au.	ana, of	45219	
4. Date post RU-486 complication began: $4/24/10$			
5. Event(s) (Please check all that apply):			
✓ Incomplete abortion Adv	verse reaction to RU-486 _	Patient hospitalize	d
Patient received a transfusion Severe blee	ding		
Other serious event (specify)			
6. Duration of event: Hours	Days	-	
7. Remarks: completed surjectly			
3. a. Name of physician who provided RU-4	86 KG/50	}	
B. b. Physician's signature	pate 5/	M.D.1	00
	*/		
end completed forms to: State M	ledical Board of Ohio		

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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JUN 0 5 2020



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	4	17	20
	Month	Day	Year
2. Name of medical practice or facility at will Parenthood	hich RU-486 was provid	ed:	
3. Address of medical practice or facility at v	which RU-486 was provi	ded:	
2314 Auburn Aus.	ana, ot	45219	
4. Date post RU-486 complication began: $5/28/20$			
5. Event(s) (Please check all that apply):			Α
∠ Incomplete abortion Adv	verse reaction to RU-486 _	Patient hospitalized	d
Patient received a transfusion Severe bleed	ding		
Other serious event (specify)			
6. Duration of event:/ Hours	Days		
7. Remarks:			
8. a. Name of physician who provided RU-48	86 Ka/JU	7	
8. b. Physician's signature	Date W	/3/1010	0.0
Send completed forms to: State M	ledical Board of Ohio		
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JUL 1 0 2020



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provide	ed:	4	2-2	Zu
		Month	Day	Year
2. Name of medical practice Planned Pare	/1	ch RU-486 was provi	ded:	
3. Address of medical practi	ce or facility at wh	ich RU-486 was pro	vided:	
2314 Auburn	Au. C	ina, of	45219	
4. Date post RU-486 complic	ration began: 4/24/70			
5. Event(s) (Please check all				
Ancomplete abortion	Advers	se reaction to RU-486	Patient hospitalized	
Patient received a transfusion	Severe bleeding			
Other serious event (specify)				
5. Duration of event:	Hours	Days		
7. Remarks: Completed sur	grally			
. a. Name of physician who p	provided RU-486	160	1/54	
. b. Physician's signature		Mly	1/2020 MD/DI)
	Da	te	1/2020	
end completed forms to:	State Medi	cal Board of Ohio		
ı	Legal Department			MARD
3	30 E. Broad St., 3 rd	Floor	MEDICA	BOARD
(Columbus, OH 432	215-6127	with!	0 5 2020



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	04	25	2019
	Month	Day	Year
2. Name of medical practice or facility at wh Planned Parenthood	ich RU-486 was provic	led:	, est
3. Address of medical practice or facility at w	hich RU-486 was prov	ided:	
2314 Auburn Aus. C	ana, of	45219	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
1 0	rse reaction to RU-485	Patient hospitalize	d
Patient received a transfusion Severe bleedinOther serious event (specify)	ag .		
(openin)			**********
5. Duration of event: Hours	2 Days		
P. Remarks: Failed med to, pt. a	ies out of to	ion + sough	t care
,			
a. Name of physician who provided RU-486	Dc.	Kally	
b. Physician's signature	Lally ite 1/29/	1000 (MO)11	20
nd completed forms to: State Medi	ical Board of Ohio		

Legal Department

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FEB 0 4 2020



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	5	13	20
	Month	Day	Year
2. Name of medical practice or facility at white Planned Parenthood	ch RU-486 was provi	ded:	
3. Address of medical practice or facility at wh	nich RU-486 was pro	vided:	
2314 Auburn Aus. C	ina, of	45219	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):		0.000	
✓ Incomplete abortion Adver	se reaction to RU-486	Patient hospitalized	1
Patient received a transfusion Severe bleeding	g		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks: completed surgicula	'		
3. a. Name of physician who provided RU-486	_Dr.	Kerley	
B. b. Physician's signature	Cicles 1/2	4/2020 MD/1	2.0
	7	17	

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

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JUL 1 0 2020



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	_ 7		20
	Month	Day	Year
2. Name of medical practice or facility at which Planned Parenthood	h RU-486 was provid	ded:	
3. Address of medical practice or facility at which	ch RU-486 was prov	ided:	
2314 Auburn Aus. Ci	na, of	45219	
4. Date post RU-486 complication began: 8/20/20			
5. Event(s) (Please check all that apply):			
Incomplete abortionAdverse	reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe bleeding			
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:			
N.			
a. Name of physician who provided RU-486		Kalson	
b. Physician's signature	maly 9/4	1/2000 (MD)/DC	2
nd completed forms to:	9/9	1 1000	

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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AUG 3 1 2020



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	9		
	Month	12	20
2. Name of medical practice or facility a Planned Parenthood	t which RU-486 was provide	Day ded:	Year
3. Address of medical practice or facility	at which RU-486 was prov	íded:	
2314 Auburn Aue.	ana of	45219	
4. Date post RU-486 complication began: $9/22/20$		(
5. Event(s) (Please check all that apply):			
Incomplete abortionA	dverse reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe bis	eding		
Other serious event (specify)			
. Duration of event: 2 Hours	Days		
. Remarks:			
N.			
a. Name of physician who provided RU-4	86	16/17	
b. Physician's signature	firely,	MAIN	0
	Date	M	.
nd completed forms to: State M	ledical Board of Ohio		
Legal Departme		Ī	MEDICAL BOAF
30 E. Broad St.,			NOV 0 9 2020

Columbus, OH 43215-6127



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:			
1. Sate no 480 was provided:	9	16	20
2. Name of medical practice or facility at which	Month n RU-486 was provi	Day ded:	Year
3. Address of medical practice or facility at which	ch RU-486 was prov	vidad:	
2314 Auburn Aus. a)	na, of	45219	
4. Date post RU-486 complication began: $\frac{10}{10}$			
5. Event(s) (Please check all that apply):			
L'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:			
			e version de la constante de l
V.			
. a. Name of physician who provided RU-486	2	Kalsy	
. b. Physician's signature	lualy	MANIN	
Date .	10/281	euro	
end completed forms to: State Medical	Board of Ohio		

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