

(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 which Planned Parenthood	RU-486 was provi	ded:	
3. Address of medical practice or facility at whic	h RU-486 was prov	vided:	-
2314 Auburn Aus. (i)	na, of	4.5219	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Incomplete abortion Fails Adverse	reaction to RU-486	Patient hospitalized	i
Patient received a transfusion Severe bleeding			
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks: Failed med the pt. wa	s out of t	town + sough	t care
a. Name of physician who provided RU-486. b. Physician's signature Date	aly 1/29	16/3 y 12000 (M.D)11	0.0
end completed forms to: State Medica	101 (01:		

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

FEB 0 4 2020



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:			
1. Dute no 400 was provided.	12		2019
	Month	Day	Year
2. Name of medical practice or facility at which	RU-486 was pro	vided:	
Planned Parenthood			
3. Address of medical practice or facility at which	ch RU-486 was pr	ovided:	
2314 Auburn Aus. (1)	na, of	45219	
4. Date post RU-486 complication began:			
2/10/20			
5. Event(s) (Please check all that apply):			
4 Incomplete abortion / ton Lo Adverse	e reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe bleeding			
Other serious event (specify)			
6. Duration of event: 2 for Swyr'r	Days		
7. Remarks: Completed Surjucilly			
٠.			
8. a. Name of physician who provided RN-486	X/D	. D. Napa 6	
8. b. Physician's signature Dat	te you	a (2/0)	0
Send completed forms to: State Medic	cal Board of Ohio		

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

 Date RU-486 was provided: 	1	3	2020
	Month	Day	Year
2. Name of medical practice or facility at	which RU-486 was provi	ded:	
Planned Parenthood			
3. Address of medical practice or facility at	t which RU-486 was pro	vided:	
2314 Auburn Aus.	ana, of	4.5219	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Uncomplete abortion/ FurtherA	dverse reaction to RU-486	Patient hospitalize	ed:
Patient received a transfusion Severe ble	eding		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks: Completed Surgicelly			
8. a. Name of physician who provided RU-	486	live	
8. b. Physician's signature	Date	1200 M.D.	

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

EB 0 7 2020



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	1	7	70
	Month	Day	Year
2. Name of medical practice or facility at Planned Parenthood		ided:	
3. Address of medical practice or facility: 2314 Auburn Am.			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Incomplete abortion	Adverse reaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion Severe b	leeding		
Other serious event (specify)			
6. Duration of event:	Days		
7. Remarks:			
8. a. Name of physician who provided Ri	U-486	Dr 18.00	let.
8. b. Physician's signature	Date		/DO 28. 20
Send completed forms to: Stat	e Medical Board of Odio	M	
Legal Depar	rtment	y	
30 E. Broad	St., 3 rd Floor	-	
Columbus	OH 43215-6127		

MEDICAL BOARD



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

Date RU-486 was provided:	01	09	2020
	Month	Day	Year
2. Name of medical practice or facility: Planned Parenthood	6	ided:	
Address of medical practice or facility	at which RU-486 was pro	vided:	
2314 Auburn Aus	. ana, of	4.5219	
4. Date post RU-486 complication began			
5. Event(s) (Please check all that apply):		A Laboratoria de la constantina della constantin	
L'Incomplete abortion / Failed _	_ Adverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe	bleeding		
Other serious event (specify)			
6. Duration of event: 2 for +	Days	-	
7. Remarks:			
3. a. Name of physician who provided R	U-486 <u>Dr.</u>	leaby	
3. b. Physician's signature	Date 1/2	9/2020 MD/1	20
end completed forms to: Stat	te Medical Board of Ohio	Alexander and the second	MEDICAL BOAI
Legal Depar			
30 E. Broad	St., 3 rd Floor		FEB 0 4 2020

Columbus, OH 43215-6127

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



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:		9	2020
	Month	VeQ	Year
2. Name of medical practice or facility at whice Planned Parenthood	h RU-486 was provi	ded:	
3. Address of medical practice or facility at whi	ich RU-486 was pro	vided:	
2314 Auburn Aus. a	ina, of	45219	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Vincomplete abortion / Fn, ledAdvers	e reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe bleeding			
Other serious event (specify)			Porticipanismo
6. Duration of event: Hours	Days		
7. Remarks: Campleted Sofically			
•			
3. a. Name of physician who provided RU-486	Dr.	Kuling	
B. b. Physician's signature	4 /	Kulsy MD)D	.0
end completed forms to: State Media		/	

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	2	26	0 -
,	Month	Day	20
2. Name of medical practice or facility at which I	RU-486 was pro	,	Year
Trannia Tarenthood			
3. Address of medical practice or facility at which	RU-486 was pr	ovided:	
2314 Auburn Aus. an	ia, of	45219	
4. Date post RU-486 complication began:			
3/13/20			
5. Event(s) (Please check all that apply):	1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	4
Pincomplete abortion HailedAdverse re	eaction to RU-486	Patient hospitalized	ı
Patient received a transfusion Severe bleeding			
Other serious event (specify)	A continuous continuous de la continuous d		
6. Duration of event: 2 Hours	_ Days		
7. Remarks:	Vincen		
5			and the same of th
8. a. Name of physician who provided RU-486		Dr. Gusahan	uz
8. b. Physician's signature	ral	1\ D.M	20
Date		4/17/20	
Send completed forms to:			

Send completed forms to

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

APR 2 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:	3	3	20
	Month	Day	Year
2. Name of medical practice or facility at whi Planned Parenthood	ich RU-486 was provid	ded:	
3. Address of medical practice or facility at wl	hich RU-486 was prov	rided:	
2314 Auburn Aus. C	ina, of	45219	
4. Date post RU-486 complication began:	20		
Event(s) (Please check all that apply):	/		
4 Incomplete abortion Adver	rse reaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion Severe bleeding	g		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks: Completed Surgically			
3. a. Name of physician who provided RU-486 3. b. Physician's signature	7	Ponsch 117/200	LD.O
end completed forms to: State Med	dical Board of Ohio		

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

APR 2 0 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	3	20
	Month	Day	Year
2. Name of medical practice or facility at v Planned Parenthood	vhich RU-486 was pr	rovided:	
3. Address of medical practice or facility at 23 14 Auburn Au. 4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply): \$\times \text{Incomplete abortion} \text{Ac}\$	iverse reaction to RU-48	6 Patient hospitalize	ed
Patient received a transfusion Severe blee Other serious event (specify)			
6. Duration of event: Hours	2_ Days		
7. Remarks: Completed Surgical	ly		
8. a. Name of physician who provided RU-4 8. b. Physician's signature	Date Pense	6/25/70 W	'D.O
Sand completed forms to:			

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	ij	10	20
	Month	Day	ZO Year
2. Name of medical practice or facility at which Planned Parenthood	ch RU-486 was provid	led:	1607
3. Address of medical practice or facility at wh	nich RU-486 was prov	ided:	
2314 Auburn Aus. C	ina, of	4.5219	
4. Date post RU-486 complication began:			
5/9/20			
5. Event(s) (Please check all that apply):			
Incomplete abortion Adver	se reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe bleeding	g		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks: blood count decreased			
8. a. Name of physician who provided RU-486	Persal		
8. b. Physician's signature Da	(a)25/7	(N.B.)	D.O.
Send completed forms to: State Med	ical Board of Ohio		
Legal Department	:		

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	4	16	20
	Month	Day	Year
2. Name of medical practice or facility at w Planned Parenthood	hich RU-486 was provid	ded:	
3. Address of medical practice or facility at	which RU-486 was prov	rided:	
2314 Auburn Aus.	ana, of	45219	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
✓ Incomplete abortion Adv	verse reaction to RU-486	Patient hospitalized	1
Patient received a transfusion Severe bleed	ding		
Other serious event (specify)			Marin and a second seco
6. Duration of event: 2 Hours	Days		
7. Remarks:		**	
3. a. Name of physician who provided RU-48	36 Con Son	hany	
8. b. Physician's signature	page 6/9/60	1.0.M	20
end completed forms to:			

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

Date RU-486 was provided:	Ц	12	20
	Month	Day	Year
2. Name of medical practice or facility at v Planned Parenthood	which RU-486 was provid	ed:	
3. Address of medical practice or facility at	which RU-486 was prov	ided:	
2314 Auburn Aus.	ana, of	45219	
4. Date post RU-486 complication began: $4/24/20$			
5. Event(s) (Please check all that apply):			
✓ Incomplete abortion Ac	dverse reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe blee	eding		
Other serious event (specify)			
6. Duration of event: 2 Hours _	Days		
7. Remarks: completed surjectly			
8. a. Name of physician who provided RU-	486 <u>KG/s</u>	}	
8. b. Physician's signature	Date 5/	M.D.1	60
Send completed forms to: State N	Medical Board of Ohio	· ·	

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

JUN 0 5 2020



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	4	17	20
	Month	Day	Year
2. Name of medical practice or facility at whice Planned Parenthood	h RU-486 was provide	ed:	
3. Address of medical practice or facility at wh 2314 Auburn Au. Co			
4. Date post RU-486 complication began: $5/28/20$			
5. Event(s) (Please check all that apply):			2
	se reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe bleeding Other serious event (specify)	g _b	Patient hospitalized	
Patient received a transfusion Severe bleeding	g	Patient hospitalized	
Patient received a transfusion Severe bleeding Other serious event (specify)	g	Patient hospitalized	
Patient received a transfusion Severe bleeding Other serious event (specify) 6. Duration of event: / Hours	g	Patient hospitalized	

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provid	ded:	4	22	Zv
		Month	Day	Year
2. Name of medical practi Planned Par-	1	RU-486 was pro	vided:	
3. Address of medical prac				
4. Date post RU-486 comp	lication began: 4/24/20			
5. Event(s) (Please check a	I that apply):			
Ancomplete abortion	Adverse r	eaction to RU-486	Patient hospitalize	d
Patient received a transfusion	on Severe bleeding			
Other serious event (specify)			
6. Duration of event:	7_ Hours	_ Days		
7. Remarks: Completed Su	gically			
8. a. Name of physician who	provided RU-486	/(6/50	
8. b. Physician's signature		aly 5/	21/1020 MB.1	0.0
Send completed forms to:		l Board of Ohio		
	Legal Department			CARD
	30 E. Broad St., 3 rd F	loor	MEDIC	AL BOARD
	Columbus, OH 4321	5-6127	111	N 0 5 2020



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

4	23	20
Month	Day	Year
ch RU-486 was provid	led:	
ina, of	45219	
rse reaction to RU-486	Patient hospitaliz	ed
ng		
Days		
6 Ovsc	honey	
ya Sprisah	M.D.	/ D.O
	ch RU-486 was provided in the RU-486 was provided and and and and and and and and and an	Month Day th RU-486 was provided: Ana, OH 45219 rese reaction to RU-486 Patient hospitalizes Days

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	5	9	272
	Month	Day	Year
2. Name of medical practice or facility Planned Parenthood		ed:	real.
3. Address of medical practice or facility	/ at which RU-486 was provi	ded:	
2314 Auburn Aus			
4. Date post RU-486 complication began			
5. Event(s) (Please check all that apply):			
	_Adverse reaction to RU-486 _	Patient hospitalize	ed
Patient received a transfusion Severe I	pleeding		
Other serious event (specify)			
6. Duration of event: 4 Hours	Days	A A A A A A A A A A A A A A A A A A A	
7. Remarks:			
ν,			
8. a. Name of physician who provided RL	J-486	unl	
3. b. Physician's signature	\mathcal{V} Date \mathcal{I}/\mathcal{I}	M.D./	D.O.
end completed forms to: State	Medical Board of Ohio		
Legal Depart	tment		
30 E. Broad	St 3 rd 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:	5	12	20
	Month	Day	Year
2. Name of medical practice or facility at w	hich RU-486 was provi	ded:	
Planned Parenthood			
3. Address of medical practice or facility at	which RU-486 was pro-	vided:	
2314 Auburn Aus.	ana, of	45219	
4. Date post RU-486 complication began: $5/19/20$			
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)			
5. Duration of event:2 Hours	Days		
7. Remarks: Completed Surgically			
3. a. Name of physician who provided RU-4	86 Strock	le	
b. Physician's signature	Date 0175		D.O
end completed forms to: State M	ledical Board of Ohio		

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		3	13	20
		Month	Day	Year
2. Name of medical practice or	facility at which R	U-486 was prov	vided:	
Planned Parent	hod			
3. Address of medical practice of	or facility at which	RU-486 was pro	ovided:	
2314 Auburn	Au. an	a, of	45219	
4. Date post RU-486 complication				
10/24/2	0			
5. Event(s) (Please check all that	t apply):			
L'Incomplete abortion	Adverse re	action to RU-486	Patient hospitalized	i
Patient received a transfusion	_ Severe bleeding			
Other serious event (specify)				
6. Duration of event:2	Hours	Days		
7. Remarks: completed	surgicular			
3. a. Name of physician who pro-	vided RU-486	Dr.	Kerly	
3. b. Physician's signature		idly	MOLI	0.0
	Date	4/	24/2020	
and				

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	5	20	20
	Month	Day	Year
2. Name of medical practice or facility at wh Planned Parenthood	ich RU-486 was provid	ded:	
3. Address of medical practice or facility at w	hich RU-486 was prov	ided:	
2314 Auburn Aus. C	ina, of	45219	
4. Date post RU-486 complication began: 6 (23/20			
5. Event(s) (Please check all that apply):			
Incomplete abortion Adver	se reaction to RU-486	Patient hospitalized	
Patient received a transfusion	necessaria de la constitución de l De la constitución de la constituci		
Other serious event (specify)			
6. Duration of event: 17 Hours	Days		
7. Remarks;			
١.		·	
8. a. Name of physician who provided RU-486	, Dr.	bal	
3. b. Physician's signature	1/22	M.D./D.C)
	ical Board of Ohio		

MEDICAL BOARD

AUG 1 7 2020

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-61:27

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



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:		6	· /	
		Month	Day	<i>70</i>
2. Name of medical practice of Planned Paren	r facility at which I HooL	RU-486 was prov	,	Year
3. Address of medical practice	or facility at which	RU-486 was pro	vided:	
2314 Auburn				
4. Date post RU-486 complicati	-			
5. Event(s) (Please check all tha	t apply):			
/Incomplete abortion	Adverse re	eaction to RU-486	Patient hosnita	hazil
Patient received a transfusion Other serious event (specify)				
5. Duration of event: 2	Hours	Days		
7. Remarks: Completed su	rý cally			
a. Name of physician who prov	vided RU-486	Dr.	Gwsdy	
b. Physician's signature	Mynsa		, -	-/D0
	Date/-	7/21	2020	
end completed forms to:	State Medical I	Board of Ohio		
	al Department			TO A BOARD
	. Broad St., 3 rd Flo		WE	DICAL BOARD
Coll	mbus, OH 43215-	6127		JUL 3 0 2020

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



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	. 7	. ^	
in the last was provided.			20
2. 1	Month	Day	Year
2. Name of medical practice or facility at whi	ch RU-486 was prov	ided:	
Planned Parenthood			
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: 8/20/20			
5. Event(s) (Please check all that apply):			
∠Incomplete abortionAdver	se reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe bleedin	g		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:			
3. a. Name of physician who provided RÜ-486	,	Dr Kalson	
3. b. Physician's signature	Maly a/	4/2020 (M.D)/1	20
	t was a		

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

AUG 3 1 2020



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	8	28	20
	Month	Day	Year
2. Name of medical practice or facility at which R Planned Parenthood	RU-486 was pro	vided:	
3. Address of medical practice or facility at which	RU-486 was pr	ovided:	
2314 Auburn Aus. ain	a, of	45219	
4. Date post RU-486 complication began: $9/(5/20)$			
5. Event(s) (Please check all that apply):			
	eaction to RU-486	Patient nospitalized	
Patient received a transfusion Severe bleeding			
Other serious event (specify)			
6. Duration of event: 2 Hours	. Days		
7. Remarks: completed Surjicalles			
3. a. Name of physician who provided RU-486	- Dr	Proside Mola	
B. b. Physician's signature Date		Ture noto	<u> </u>
and completed forms to			

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

OCT 1 9 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	/2	20
	Month	Day	Year
2. Name of medical practice or facility Planned Parenthoo	y at which RU-486 was pro	vided:	750
3. Address of medical practice or facil	ity at which RU-486 was pro	ovided:	
2314 Auburn Au			
4. Date post RU-486 complication beg $9/22/20$	an:		
5. Event(s) (Please check all that apply	/):		
Incomplete abortion	Adverse reaction to RU-486	Patient hospitaliz	zed
Patient received a transfusion Sever	e bleeding		
Other serious event (specify)			
5. Duration of event: 2 Hour	s Days	***	
7. Remarks:			
N.			
a. Name of physician who provided I		16/15	
b. Physician's signature	finales	JUR!	'D.O
	Date	2000	
end completed forms to: Sta	te Medical Board of Ohio		
Legal Depa	ırtment		MEDICAL BOAR

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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

1

NOV 09 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	16	-20
·	Month	Day	
2. Name of medical practice or facility at which Parenthood	1 RU-486 was prov	/ided:	Year
3. Address of medical practice or facility at white	ch RU-486 was pro	ovided:	
2314 Auburn Aue. al			
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)			
6. Duration of event: 2 Hours	Days		
7. Remarks:			
V.		•	i
3. a. Name of physician who provided RU-486	2	Kalsy	
b. Physician's signature	bully 12/2	MOLD	0
Date	1012	8/ 2010	
end completed forms to: State Medica	Board of Ohio		

MEDICAL BOARD

NOV 09 2020

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

Legal Department

30 E. Broad St., 3rd Floor Columbus, OH 43215-61:27



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	_/0	6	
	Month	Day	Year
2. Name of medical practice or facility at which Planned Parenthood	ch RU-486 was provid	ed:	rear
3. Address of medical practice or facility at wh	ich RU-486 was provi	ded:	
2314 Auburn Aus. a			
4. Date post RU-486 complication began:			
40 for 11/12/20			
5. Event(s) (Please check all that apply):			
2 Incomplete abortion Adverse	e reaction to RU-486	_ Patient hospitalized	
Patient received a transfusion Severe bleeding		de tempologico monte de demologico de demologico monte de diferencia de la composição de la composição de la c	
Other serious event (specify)			
Duration of event: 2 Hours	Days		
Remarks:			
`			
a. Name of physician who provided RU-486		In Pidal	
b. Physician's signature	X	(MD/D	0
Date of completed forms to: State Medica		12/1/2000	
l egal Department	al Board of Ohio		
Legal Denortment			

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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

MEDICAL BOARD

DEC 07 2020



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

J			
1. Date RU-486 was provided:	-	7	20
	Month	Day	Year
2. Name of medical practice or facility a Planned Parenthood	at which RU-486 was pro	vided:	1541
3. Address of medical practice or facility	at which RU-486 was pro	Wided:	
2314 Auburn Aue.	ana, of	45219	
4. Date post RU-486 complication began	:		
12/1/20			
5. Event(s) (Please check all that apply):			
12	Adverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe bl	leeding		
Other serious event (specify)			
. Duration of event: Hours	Days		
Remarks:	,		
\			
a. Name of physician who provided RU-	486 <u>Dr.</u>	ling	
b. Physician's signature	Date 12/7	MD/DI	Δ
d completed forms to: State N	Medical Board of Ohio		
Legal Departm			
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MEDICAL BOARD

DEC 1 6 2020

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

Prescribed: \$/--/2011, Rev. 12/13/12



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		/3	20
2 14	Month	Day	Year
2. Name of medical practice or facility Planned Parenthoo	y at which RU-486 was provi	ded:	
3. Address of medical practice or facility	ty at which RU-486 was pro	vided:	
2314 Auburn Aus	. ana, of	45219	
4. Date post RU-486 complication began	ın:		
5. Event(s) (Please check all that apply)	:		
h	_ Adverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe	bleeding		
Other serious event (specify)			
5. Duration of event: 2 Hours	Days		
7. Remarks:			
٠,			
	J-486 /),	- Port	
a. Name of physician who provided RL b. Physician's signature	J-486	. Pyroth).
a. Name of physician who provided RL		· Penol	
a. Name of physician who provided RL b. Physician's signature		00/00	

30 E. Broad St., 3rd Floor Columbus, OH 43215-6127 MEDICAL BOARD

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