

(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 a Planned Parenthood	vhich RU-486 was provid	ed:	
3 Address of medical practice on facility of	ali la più anc		
3. Address of medical practice or facility at			
2314 Auburn Aus.	ana, of	45219	
4. Date post RU-486 complication began:	120		
5. Event(s) (Please check all that apply):	- I was a second of the second		
4 Incomplete abortionAc	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 Surgically			
,			
8. a. Name of physician who provided RU-4	86 <u>Dr.</u> 1	Porsch	
8. b. Physician's signature	7	17/20	0.0
	Date 3/	17/m	
Send completed forms to: State N	ledical Board of Ohio		
Legal Departm	ent		
30 E. Broad St.,	3 rd 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:	5	12	20
	Month	Day	Year
2. Name of medical practice or facility at w Planned Parenthood	vhich RU-486 was provi	ided:	
3. Address of medical practice or facility at	which RU-486 was pro	vided:	
2314 Auburn Au.	ana, of	45219	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Incomplete abortionAd	verse reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe blee	ding		
Other serious event (specify)			
6. Duration of event: 2 Hours	Days		
7. Remarks: Completed Surgically			
*			
. a. Name of physician who provided RU-4	86 foroco	le	
. b. Physician's signature		63.	D.O
	Date	12000	
end completed forms to: State M	ledical Board of Ohio		

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

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:	8	28	
	Month	Day	
2. Name of medical practice or facility at which	1 RU-486 was prov	ided:	Year
3. Address of medical practice or facility at which	ch RU-486 was pro	vided:	
2314 Auburn Aus. Ci.	na, of	45219	
4. Date post RU-486 complication began: $9/(5/29)$			
5. Event(s) (Please check all that apply):			
	reaction to RU-486	Patient hospitalized	
Other serious event (specify)			
6. Duration of event: Hours	_ Days		
7. Remarks: Completed Surgically			
3. a. Name of physician who provided RU-486	- Dr	Prosile	
B. b. Physician's signature Date	10111	we major	
end 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:		/3	20
	Month	Day	Year
2. Name of medical practice or facility at will planned Parenthood	hich RU-486 was provid	ed:	
3. Address of medical practice or facility at w	vhich RU-486 was provid	ded:	
2314 Auburn Aus. (
4. Date post RU-486 complication began:		,	
5. Event(s) (Please check all that apply):			
h.	erse reaction to RU-486	_ Patient hospitalized	
Patient received a transfusion Severe bleedir	ng		
Other serious event (specify)			
5. Duration of event: 2 Hours	Days		
7. Remarks:			
٠,			
a. Name of physician who provided RU-486	Dr.	Person	
b. Physician's signature		oa Car	
Da	ite 2/[0]	vu	
nd completed forms to: State Medi	ical Board of Ohio		

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

DEC 1 6 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	3	70
	Month	Day	Year
2. Name of medical practice or facility at Planned Parenthood	which RU-486 was provi	ded:	
3. Address of medical practice or facility a	t which RU-486 was prov	vided:	
2314 Auburn Au.	ana, of	45219	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
✓ Incomplete abortion A	dverse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Severe ble	eding		
Other serious event (specify)			
6. Duration of event: Hours	2 Days		
7. Remarks: Completed Surgical	ly		
3. a. Name of physician who provided RU-	486 Pensole	75	
3. b. Physician's signature	Date (6)	25/20 WD/	D.O
and completed forms to:	Madical Decad of Ohio		

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

JUL 1 0 2020



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

Date RU-486 was provided:		10	20
	Month	Day	Year
2. Name of medical practice or facility		ded:	
Planned Parenthood			
3. Address of medical practice or facility	y at which RU-486 was prov	vided:	
2314 Auburn Au	. Cina, of	45219	
4. Date post RU-486 complication began	n:		
\$19/20			
5. Event(s) (Please check all that apply):			
Incomplete abortion	_ Adverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion <u>\$\mathcal{L}\$</u> Severe	bleeding		
Other serious event (specify)			-
6. Duration of event: Hours	Days		
7. Remarks:	0		
blood count decreased			
,			
8. a. Name of physician who provided R	U-486 Parsal		
8. b. Physician's signature	2	(MP/D	0
	Date	7070	
Send completed forms to: Stat	e Medical Board of Ohio		
Legal Depa	rtment		
30 E. Broad	St., 3 rd Floor		DOADD
Columbus.	OH 43215-6127	MED	ICAL BOARD

Columbus, OH 43215-6127

JUL 1 0 2020

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