MEDICAL BOARD

FEB 03 2020

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: _____ Month _____ Day _____ Year

2. Name of medical practice or facility at which RU-486 was provided:
The founder's Women's Health Center

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St.
Col's, OH 43205

4. Date post RU-486 complication began:
1-30-20

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 medical abortion

6. Duration of event: _____ Hours 14 Days

7. Remarks: Patient had failed medical abortion and was sent to The Women's Med Center in Dayton, Ohio for surgical abortion

8. a. Name of physician who provided RU-486 Karl I. Schaeffer, MD

8. b. Physician's signature Karl D. Schaeffer M.D/D.O

Date 1-30-20

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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: 02 (Month) 06 (Day) 2020 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
The founder's Women's Health Ctr.

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St.
Col's, OH 43205

4. Date post RU-486 complication began:
3-18-20

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 abortion

6. Duration of event: _____ Hours 35 Days

7. Remarks: Patient didn't follow-up for post-ab care and returned on 3/18/20 for evaluation U.S. revealed a 10 week gestation. Patient referred to Karl Schaeffer Women's Med Center in Dayton, Oh for surgical abortion.

8. a. Name of physician who provided RU-486 Karl Schaeffer, MD

8. b. Physician's signature Karl Schaeffer, MD MD/DO

Date 3-24-20

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

MEDICAL BOARD
MAR 27 2020

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

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: 2 (Month) 18 (Day) 20 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
The founder's Women's Health Ctr.

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St.
Columbus, OH 43205

4. Date post RU-486 complication began:
3-3-20

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: _____ Hours 14 Days

7. Remarks: Patient had failed medical abortion and will be sent for surgical abortion at Women's Med Center in Dayton, Ohio.

8. a. Name of physician who provided RU-486 Karl I. Schaeffer, MD

8. b. Physician's signature Karl I. Schaeffer (M.D/D.O___

Date 3-3-20

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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: 03 (Month) 19 (Day) 2020 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
The founder's Women's Health Ctr.

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St.
Columbus, OH 43205

4. Date post RU-486 complication began: 3-24-20

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 abortion

6. Duration of event: _____ Hours 7 Days

7. Remarks: Patient had failed medical abortion and will be sent for surgical abortion at the Women's Med Center in Dayton, Ohio.

8. a. Name of physician who provided RU-486 Karl I. Schaeffer

8. b. Physician's signature Karl I. Schaeffer (M.D./D.O.)

Date 3-24-20

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

MEDICAL BOARD
MAR 27 2020

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: _____
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
The Founder's Women's Health Center

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St. Columbus, OH 43025

4. Date post RU-486 complication began:
3-27-20 or 3-28-20

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 medical abortion

6. Duration of event: _____ Hours 14 Days

7. Remarks: Patient returned on 4/9/20 for follow-up. Patient had a failed medical abortion and will be sent to The Women's Med Center in Dayton, Ohio for surgical abortion.

8. a. Name of physician who provided RU-486 Karl I. Schaeffer

8. b. Physician's signature Karl I. Schaeffer MD/DO

Date 4-9-20

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 2020

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

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: _____
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
The founder's Women's Health Ctr.

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St.
Columbus, OH 43205

4. Date post RU-486 complication began:
4-2-20

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 Medical abortion

6. Duration of event: _____ Hours 14 Days

7. Remarks:
Patient sent to The Women's Med Center in Dayton, Ohio for surgical abortion

8. a. Name of physician who provided RU-486 Karl F. Schaeffer

8. b. Physician's signature Karl Schaeffer. (M.D)/D.O

Date 4-7-20

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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: 04 (Month) 23 (Day) 20 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
The founder's Women's Health Center

3. Address ~~of medical practice or facility at which RU-486 was provided:~~
1243 E. Broad St. Columbus, OH 43205

4. Date post RU-486 complication began: 4-27-20

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 abortion

6. Duration of event: _____ Hours 14 Days

7. Remarks:
Patient was sent to Planned Parenthood for surgical abortion.

8. a. Name of physician who provided RU-486 Karl I Schaeffer

8. b. Physician's signature Karl I Schaeffer (M.D./D.O)

Date 5-7-20

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

MEDICAL BOARD
MAY 11 2020

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: 04 (Month) 14 (Day) 2020 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
The founder's Women's Health Center

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St.
Col's, OH 43205

4. Date post RU-486 complication began:
4-30-20

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 abortion

6. Duration of event: _____ Hours 16 Days

7. Remarks: Patient will be sent for surgical abortion at the Women's Med Center in Dayton, Ohio on 5-1-20

8. a. Name of physician who provided RU-486 Karl I Schaeffer

8. b. Physician's signature Karl I. Schaeffer (M.D./D.O.)

Date 4-30-20

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

MEDICAL BOARD
MAY 01 2020

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: 04 (Month) 30 (Day) 2020 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
The founder's Women's Health Ctr.

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St. Col's, OH 43205

4. Date post RU-486 complication began: 5-14-20

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 medical abortion.

6. Duration of event: _____ Hours 14 Days

7. Remarks: Patient was sent to Women's Med Center in Dayton, Ohio for surgical abortion

8. a. Name of physician who provided RU-486 Karl I. Schaeffer

8. b. Physician's signature Karl I. Schaeffer M.D./D.O

Date 5-19-20

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

MEDICAL BOARD
MAY 22 2020

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: 5 (Month) 7 (Day) 20 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
The founder's Women's Health Center

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St. Col's, OH 43205

4. Date post RU-486 complication began: 5-13-20

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 Medical abortion

6. Duration of event: _____ Hours 7 Days

7. Remarks:
Patient was sent to Women's Med Center in Dayton, Ohio for a surgical abortion

8. a. Name of physician who provided RU-486 Karl T. Schaeffer

8. b. Physician's signature Karl D. Schaeffer (M.D) / D.O

Date 5-13-20

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

MEDICAL BOARD
MAY 18 2020

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: 05 (Month) 12 (Day) 2020 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
The founder's Women's Health Center

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St. Columbus, OH 43205

4. Date post RU-486 complication began:
5-26-20

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 abortion 2° to Throwing up pills

6. Duration of event: _____ Hours 14 Days

7. Remarks: Patient was sent for surgical abortion to Women's Med Center in Dayton, Ohio,

8. a. Name of physician who provided RU-486 Karl I Schaeffer

8. b. Physician's signature Karl Schaeffer (M.D. / D.O)

Date 5-27-20

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

MEDICAL BOARD
JUN 05 2020

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: 05 (Month) 26 (Day) 2020 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
The founder's Women's Health Ctr.

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St. Columbus, OH 43205

4. Date post RU-486 complication began: 6-9-20

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 medical abortion

6. Duration of event: _____ Hours 14 Days

7. Remarks: Patient will be sent to Women's Med Center in Dayton, Ohio for surgical abortion.

8. a. Name of physician who provided RU-486 Karl I. Schaetter

8. b. Physician's signature Karl I. Schaetter M.D / D.O

Date 6-9-20

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

MEDICAL BOARD
JUN 12 2020

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: 06 (Month) 07 (Day) 20 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
The founder's Women's Health Ctr

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St. Col's, OH 43205

4. Date post RU-486 complication began:
06/16/20

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 abortion

6. Duration of event: _____ Hours 7 Days

7. Remarks: Patient was sent for surgical abortion at the Women's Med center in Dayton, Ohio.

8. a. Name of physician who provided RU-486 Karl F. Schaeffer

8. b. Physician's signature Karl F. Schaeffer (M.D./D.O)

Date 6-17-20

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