

State Medical Board of Ohio
Report of RU-486 Event

MEDICAL BOARD

FEB 03 2020

(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. Columbus, OH 43205		
4. Date post RU-486 complication began: 1-30-20		
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) Failed medical abortion		
6. Duration of event: _____ Hours <u>14</u> 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 I. 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	06	2020
	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. Col's, OH 43205			
4. Date post RU-486 complication began: 3-18-20			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>Failed abortion</u>			
6. Duration of event: _____ Hours <u>35</u> 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			
8. a. Name of physician who provided RU-486 <u>Karl Schaeffer, Women's Med Center, Dayton, OH</u>			
8. b. Physician's signature <u>Karl Schaeffer, MD</u> <u>for medical abortion</u> M.D./D.O.			
Date <u>3-24-20</u>			

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MEDICAL BOARD

MAR 27 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:	<u>2</u>	<u>18</u>	<u>20</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>The founder's Women's Health Ctr.</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 E. Broad St.</u> <u>Columbus, OH 43205</u>			
4. Date post RU-486 complication began: <u>3-3-20</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>14</u> Days			
7. Remarks: <u>Patient had failed medical abortion and will be sent for surgical abortion at Women's Med Center in Dayton, Ohio.</u>			
8. a. Name of physician who provided RU-486 <u>Karl I. Schaeffer, MD</u>			
8. b. Physician's signature <u>Karl I. Schaeffer</u> (M.D./D.O.) Date <u>3-3-20</u>			

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Legal Department
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MEDICAL BOARD
MAR 06 2020

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:	<u>03</u>	<u>19</u>	<u>2020</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>The Founder's Women's Health Ctr.</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 E. Broad St.</u> <u>Columbus, OH 43205</u>			
4. Date post RU-486 complication began: <u>3-24-20</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed abortion</u>			
6. Duration of event: _____ Hours <u>7</u> Days			
7. Remarks: <u>Patient had failed medical abortion and will be sent for surgical abortion at the Women's Med Center in Dayton, Ohio.</u>			
8. a. Name of physician who provided RU-486 <u>Karl I. Schaeffer</u>			
8. b. Physician's signature <u>Karl I. Schaeffer</u> <u>(M.D./D.O.)</u>			
Date <u>3-24-20</u>			

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MEDICAL BOARD

MAR 27 2020

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): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>Failed medical abortion</u>		
6. Duration of event: _____ Hours <u>14</u> Days		
7. Remarks: <u>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.</u>		
8. a. Name of physician who provided RU-486 <u>Karl I. Schaeffer</u>		
8. b. Physician's signature <u>Karl I. Schaeffer</u> <u>M.D./D.O.</u>		
Date <u>4-9-20</u>		

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MEDICAL BOARD

APR 13 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 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): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> 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 E Schaeffer		
8. b. Physician's signature Karl Schaeffer M.D./D.O. Date 4-2-20		

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MEDICAL BOARD

APR 06 2020

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:	<u>04</u>	<u>23</u>	<u>20</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>The founder's Women's Health Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 E. Broad St. Columbus, OH 43205</u>			
4. Date post RU-486 complication began: <u>4-27-20</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>Failed abortion</u>			
6. Duration of event: _____ Hours <u>14</u> Days			
7. Remarks: <u>Patient was sent to Planned Parenthood for surgical abortion.</u>			
8. a. Name of physician who provided RU-486 <u>Karl I Schaeffer</u>			
8. b. Physician's signature <u>Karl I Schaeffer</u> <u>(M.D./D.O.)</u>			
Date <u>5-7-20</u>			

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MEDICAL BOARD

MAY 11 2020

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:	<u>04</u>	<u>14</u>	<u>2020</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>The Founder's Women's Health Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 E. Broad St.</u> <u>Cel's, OH 43205</u>			
4. Date post RU-486 complication began: <u>4-30-20</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>Failed abortion</u>			
6. Duration of event: _____ Hours <u>16</u> Days			
7. Remarks: <u>Patient will be sent for surgical abortion</u> <u>at the Women's Med Center in Dayton, Ohio</u> <u>on 5-1-20</u>			
8. a. Name of physician who provided RU-486 <u>Karl I Schaeffer</u>			
8. b. Physician's signature <u>Karl I. Schaeffer</u> <u>M.D./D.O.</u>			
Date <u>4-30-20</u>			

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MEDICAL BOARD

MAY 01 2020

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:	<u>04</u>	<u>30</u>	<u>2020</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>The founder's Women's Health Ctr.</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 E. Broad St. Col's, OH 43205</u>			
4. Date post RU-486 complication began: <u>5-14-20</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>Faked medical abortion.</u>			
6. Duration of event: _____ Hours <u>14</u> Days			
7. Remarks: <u>Patient was sent to Women's Med Center in Dayton, Ohio for surgical abortion</u>			
8. a. Name of physician who provided RU-486 <u>Karl J. Schaeffer</u>			
8. b. Physician's signature <u>Karl J. Schaeffer</u> <u>M.D./D.O.</u>			
Date <u>5-19-20</u>			

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MEDICAL BOARD

MAY 22 2020

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:	<u>5</u>	<u>7</u>	<u>20</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>The founder's Women's Health Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 E. Broad St. Col's, OH 43205</u>			
4. Date post RU-486 complication began: <u>5-13-20</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>Failed Medical abortion</u>			
6. Duration of event: _____ Hours <u>7</u> Days			
7. Remarks: <u>Patient was sent to Women's Med Center in Dayton, Ohio for a surgical abortion</u>			
8. a. Name of physician who provided RU-486 <u>Karl I. Schaeffer</u>			
8. b. Physician's signature <u>Karl I. Schaeffer</u> (M.D.) / D.O. Date <u>5-13-20</u>			

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MEDICAL BOARD

MAY 18 2020

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:	<u>05</u>	<u>12</u>	<u>2020</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>The founder's Women's Health Center</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 E. Broad St. Columbus, OH 43205</u>			
4. Date post RU-486 complication began: <u>5-26-20</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>Failed abortion 2^o to Throwing up pills</u>			
6. Duration of event: _____ Hours <u>14</u> Days			
7. Remarks: <u>Patient was sent for surgical abortion to Women's Med Center in Dayton, Ohio,</u>			
8. a. Name of physician who provided RU-486 <u>Karl I Schaeffer</u>			
8. b. Physician's signature <u>Karl Schaeffer</u> <u>(M.D. / D.O.)</u>			
Date <u>5-27-20</u>			

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MEDICAL BOARD

JUN 05 2020

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:	<u>05</u>	<u>26</u>	<u>2020</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>The founder's Women's Health Ctr.</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1243 E. Broad St. Columbus, OH 43205</u>			
4. Date post RU-486 complication began: <u>6-9-20</u>			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>failed medical abortion</u>			
6. Duration of event: _____ Hours <u>14</u> Days			
7. Remarks: <u>Patient will be sent to Women's Med Center in Dayton, Ohio for surgical abortion.</u>			
8. a. Name of physician who provided RU-486 <u>Karl J. Schaeffer</u>			
8. b. Physician's signature <u>Karl J. Schaeffer</u> <u>M.D./D.O.</u>			
Date <u>6-9-20</u>			

Send completed forms to: State Medical Board of Ohio

Legal Department

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Columbus, OH 43215-6127

MEDICAL BOARD

JUN 18 2020

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	07	20
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: The Founders Women's Health Ctr			
3. Address of medical practice or facility at which RU-486 was provided: 1243 E. Broad St. Ctl's, OH 43205			
4. Date post RU-486 complication began: 06/16/20			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>Failed abortion</u>			
6. Duration of event: _____ Hours <u>7</u> Days			
7. Remarks: <u>Patient was sent for surgical abortion at the Women's Med center in Dayton, Ohio.</u>			
8. a. Name of physician who provided RU-486 <u>Karl T. Schaeffer</u>			
8. b. Physician's signature <u>Karl T. Schaeffer</u> (M.D./D.O.)			
Date <u>6-17-20</u>			

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MEDICAL BOARD

JUN 24 2020