

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

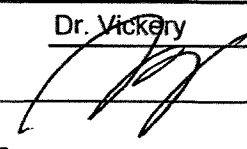
1. Date RU-486 was provided:	<u>1</u>	<u>13</u>	<u>22</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Rd. Bedford Hts. Ohio 44146			
4. Date post RU-486 complication began: 1/20/22			
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: <u>1</u> Hours _____ Days			
7. Remarks: Mab procedure was initiated per FDA regimen on 1/13/22. Pt. called on 1/20/22 with c/o little to no bleeding. US performed on 1/21/22 confirmed continuing pregnancy. Surgical aspiration was performed 1/27/22; pt. did well post op.			
8. a. Name of physician who provided RU-486 <u>Dr. Vickery</u>			
8. b. Physician's signature _____ M.D. / D.O. _____ Date _____			

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:	<u>1</u>	<u>7</u>	<u>22</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Rd. Bedford Hts. Ohio 44146			
4. Date post RU-486 complication began: 1/11/22			
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: <u>1</u> Hours _____ Days			
7. Remarks: MAB procedure was initiated per FDA regimen on 1/7/22. Pt. called on 1/10/22 with c/o continued nausea. US performed on 1/11/22 revealed incomplete abortion. Surgical aspiration was performed 1/11/22; pt. did well post op.			
8. a. Name of physician who provided RU-486		Dr. Vickery	
8. b. Physician's signature			
		M.D. / D.O.	
		Date _____	

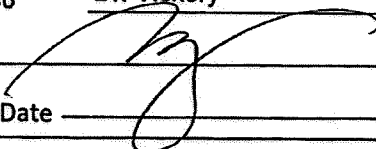
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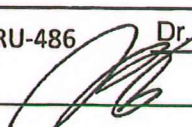
1. Date RU-486 was provided:	12	9	2021
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Rd. Bedford Hts. Ohio 44146			
4. Date post RU-486 complication began: 12/14/21			
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: 1 _____ Hours _____ Days			
7. Remarks: MAB procedure was initiated per FDA regimen on 12/9/21. F/U call on 12/14/21 revealed pt. had an US at her OB office that revealed a continuing pregnancy. Surgical aspiration was performed on 12/17/21. Pt. did well post op.			
8. a. Name of physician who provided RU-486 Dr. Vickery			
8. b. Physician's signature  M.D. / D.O. _____			
Date _____			

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1. Date RU-486 was provided:	<u>12</u>	<u>2</u>	<u>21</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Rd. Bedford Hts. Ohio 44146			
4. Date post RU-486 complication began: 1/14/22			
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: <u>1</u> Hours <u> </u> Days			
7. Remarks: MAB procedure was initiated per FDA regimen on 12/2/21. Pt. called on 1/14/22 with c/o +HSPT US performed on 1/20/22 revealed continuing pregnancy. Surgical aspiration was performed 1/20/22; pt. did well post op.			
8. a. Name of physician who provided RU-486 <u>Dr. Vickery</u>			
8. b. Physician's signature <u></u> M.D. / D.O. _____			
Date <u> </u>			

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1. Date RU-486 was provided:	<u>10</u>	<u>12</u>	<u>2021</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Rd. Bedford Hts. Ohio 44146			
4. Date post RU-486 complication began: 11/18/21			
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: <u>1</u> Hours _____ Days			
7. Remarks: MAB procedure was initiated per FDA regimen on 10/12/21. FU US on 11/18/21 revealed Continuing pregnancy. Pt. preferred to continue pregnancy and was advised to seek care with her OBGYN asap.			
8. a. Name of physician who provided RU-486 <u>Dr. Brant</u>			
8. b. Physician's signature <u></u> <u>MD / D.O.</u>			
Date <u>12-21-21</u>			

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1. Date RU-486 was provided:	<u>7</u>	<u>14</u>	<u>2021</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Rd. Bedford Hts., Oh 44146			
4. Date post RU-486 complication began: 7/15/21			
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: <u>1</u> Hours _____ Days			
7. Remarks: MAB procedure was initiated per FDA regimen on 7/14/21. Pt. called on 7/15/21 c/o little to no bleeding in 24 hours. US on 7/16/21 revealed continuing pregnancy. Surgical aspiration was performed 7/16/21; pt. did well post op.			
8. a. Name of physician who provided RU-486 <u>Dr. Vickery</u>			
8. b. Physician's signature _____ Date <u>8/26/2021</u> <u>MD/D.O.</u>			

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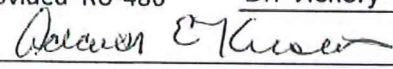
MEDICAL BOARD

OCT 14 2021

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1. Date RU-486 was provided:	<u>7</u>	<u>14</u>	<u>2021</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Rd. Bedford Hts., Oh 44146			
4. Date post RU-486 complication began: 7/15/21			
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: <u>1</u> Hours _____ Days			
7. Remarks: MAB procedure was initiated per FDA regimen on 7/14/21. Pt. called on 7/15/21 c/o little to no bleeding in 24 hours. US on 7/16/21 revealed continuing pregnancy. Surgical aspiration was performed 7/16/21; pt. did well post op.			
8. a. Name of physician who provided RU-486 <u>Dr. Vickery</u>			
8. b. Physician's signature <u></u> <u>M.D./D.O.</u>			
Date <u>10/7/2021</u>			

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MEDICAL BOARD

State Medical Board of Ohio Report of RU-486 Event

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To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>7</u>	<u>8</u>	<u>2021</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Rd. Bedford Hts., Oh 44146			
4. Date post RU-486 complication began: 7/12/21			
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: <u>1</u> Hours _____ Days			
7. Remarks: MAB procedure was initiated per FDA regimen on 7/8/21. Pt. called on 7/12/21 c/o little to no bleeding. US on 7/14/21 revealed continuing pregnancy. 2nd dose of misoprostol given. Pt. called on 7/20/21 stating she had no bleeding/cramping after 2nd dose of miso. US on 7/22/21 revealed continuing pregnancy. Pt. declined aspiration and preferred to continue pregnancy.			
8. a. Name of physician who provided RU-486 <u>Dr. Vickery</u>			
8. b. Physician's signature <u><i>Gleason E. Kiser</i></u> <u>M.D./D.O.</u>			
Date <u>10/07/2021</u>			

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1. Date RU-486 was provided:	<u>7</u>	<u>8</u>	<u>2021</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Rd. Bedford Hts., Oh 44146			
4. Date post RU-486 complication began: 7/12/21			
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: <u>1</u> Hours _____ Days			
7. Remarks: MAB procedure was initiated per FDA regimen on 7/8/21. Pt. called on 7/12/21 c/o little to no bleeding. US on 7/14/21 revealed continuing pregnancy. 2nd dose of misoprostol given. Pt. called on 7/20/21 stating she had no bleeding/cramping after 2nd dose of miso. US on 7/22/21 revealed continuing pregnancy. Pt. declined aspiration and preferred to continue pregnancy.			
8. a. Name of physician who provided RU-486 <u>Dr. Vickery</u>			
8. b. Physician's signature _____ M.D. / D.O. _____			
Date <u>8/26/2021</u>			

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MEDICAL BOARD

OCT 14 2021



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>14</u>	<u>21</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood of Greater Ohio</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>25350 Rockside Rd Bedford Hts, OH 44146</u>			
4. Date post RU-486 complication began: <u>6.30.21</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 checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>1</u> Hours _____ Days			
7. Remarks: <u>Mab procedure was initiated per FDA regimen per PPA protocol. Pt called on 6.18.21 with vlb bleeding. US revealed debris. Pt called on 6.30.21 with vlb continued bleeding hgb was <7 pt referred to ER.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Vickers</u>			
8. b. Physician's signature <u>[Signature]</u> <u>M.D. / D.O.</u>			
Date _____			

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Legal Department
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Columbus, OH 43215-6127

MEDICAL BOARD OF OHIO

AUG 17 2021



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>21</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood of Greater Ohio.</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>25350 Rockside Rd. Bedford Hts OH 44146</u>			
4. Date post RU-486 complication began: <u>6.15.21</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 MAB</u>			
6. Duration of event: <u>1</u> Hours _____ Days			
7. Remarks: <u>Mab was initiated per FPA regimen on 5.7.21. Pt called with @HAT on 6.15.21. US performed on 6.15.21, revealed continuing pregnancy. Surgical aspiration was performed 6.16.21; Pt did well post op.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Hickery.</u>			
8. b. Physician's signature _____ M.D. / D.O. _____ Date <u>7/2/21</u>			

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MEDICAL BOARD

AUG 17 2021