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: 1 (Month) 13 (Day) 22 (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):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 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 Dr. Vickery

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

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: 1 (Month) 7 (Day) 22 (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):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 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 _____

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

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: 12 (Month) 9 (Day) 2021 (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):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ 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 _____

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

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

JAN 19 2022
STATE MEDICAL BOARD OF OHIO

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: 12 (Month) 2 (Day) 21 (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):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours _____ 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 Dr. Vickery

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

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: 10 (Month) 12 (Day) 2021 (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):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 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 Dr. Brant

8. b. Physician's signature Ashley R Brant M.D. / D.O

Date 12-21-21

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

JAN 19 2022
STATE MEDICAL BOARD OF OHIO

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: 7 (Month) 14 (Day) 2021 (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):

__X__ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 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 Dr. Vickery

8. b. Physician's signature _____ M.D. /D.O

Date 8/26/2021

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

MEDICAL BOARD
OCT 14 2021

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: 7 (Month) 14 (Day) 2021 (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):

__X__ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 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 Dr. Vickery

8. b. Physician's signature [signature] M.D./D.O

Date 10/7/2021

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

MEDICAL BOARD
OCT 14 2021

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: 7 (Month) 8 (Day) 2021 (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):

__X__ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 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 Dr. Vickery

8. b. Physician's signature [signature] M.D./D.O

Date 10/07/2021

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

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

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: 7 (Month) 8 (Day) 2021 (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):

__X__ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 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 Dr. Vickery

8. b. Physician's signature _____ M.D. / D.O

Date 8/26/2021

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

MEDICAL BOARD
OCT 14 2021

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) 14 (Day) 21 (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:
6.30.21

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: 1 Hours _____ Days

7. Remarks: Med procedure was initiated per FDA regimen per PPGA protocol. Pt called on 6.18.21 with c/o bleeding. US revealed debris. Pt called on 6.30.21 with c/o continued bleeding hgb was <7 pt referred to ER.

8. a. Name of physician who provided RU-486 Dr. Vickers

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

MEDICAL
AUG 17 2021

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) 21 (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:
6.15.21

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 MAB

6. Duration of event: 1 Hours _____ Days

7. Remarks: Mab was initiated per FDA regimen on 5.7.21 Pt called with HCG on 6.15.21. US performed on 6.15.21, revealed continuing pregnancy. Surgical aspiration was performed 6.18.21; pt did well post op.

8. a. Name of physician who provided RU-486 Dr. Nikery.

8. b. Physician's signature _____ M.D. / D.O

Date 7/2/21

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

MEDICAL BOARD
AUG 17 2021

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