(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	1	13	22
	Month	Day	Year
2. Name of medical practice or facility at	which RU-486 was provi	ded:	
Planned Parenthood of Greater Ohi	0		
		• • •	
3. Address of medical practice or facility a	at which KU-486 was prov	videa:	
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 hospitalize	ed
Patient received a transfusion Severe b	leeding		
Other serious event (specify)			
6. Duration of event: 1 Hours	Days		
7. Remarks: Mab procedure was initiated little to no bleeding. US performed on 1/2 performed 1/27/22; pt. did well post op.	•		
8. a. Name of physician who provided RU	J-486 Dr Vickery		
8. b. Physician's signature	Date	M.D.,	/ D.O
Send completed forms to: State	e Medical Board of Ohio		
Legal Depar	tment		
30 E. Broad	St., 3 rd Floor		
Columbus (OH 43215-6127		

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	1	7	22
	Month	Day	Year
2. Name of medical practice or facility at	which RU-486 was provi	ded:	
Planned Parenthood of Greater Ohio	0		
3. Address of medical practice or facility a	it which RU-486 was prov	vided:	
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 hospitaliz	ed
Patient received a transfusion Severe ble	eeding		
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 reveale			
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 Departi	ment		
30 E. Broad S	it., 3 rd Floor		
Columbus, O	H 43215-6127		



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	12	9	2021
	Month	Day	Year
Name of medical practice or facility at a Planned Parenthood of Greater Ohio		ded:	
3. Address of medical practice or facility at 25350 Rockside Rd. Bedford Hts.	which RU-486 was prov	rided:	
4. Date post RU-486 complication began: 12/14/21			
5. Event(s) (Please check all that apply):			
X Incomplete abortionA	dverse reaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion Severe blee	eding		
Other serious event (specify)			and the control of th
6. Duration of event: 1 Hours	Days		
7. Remarks: MAB procedure was initiated an US at her OB office that revealed a cont Pt. did well post op.	per FDA regimen on 12/ inuing pregnancy. Surg	9/21. F/U call on 1 ical aspiration was	2/14/21 revealed pt. had performed on 12/17/21
3. a. Name of physician who provided RU-	486 Dr. Vickery		
3. b. Physician's signature	Date	M.D.	/ D.O
Send completed forms to: State I	Medical Board of Ohio		
Legal Departn			
•	., 3 rd Floor		
an E. Bload St			

JAN 19 2022

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	12	2	21
	Month	Day	Year
2. Name of medical practice or facility	at which RU-486 was provi	ded:	
Planned Parenthood of Greater O	hio		
2. Address of modical prosting on the tite			
3. Address of medical practice or facility	y at which RU-486 was prov	/ided:	
25350 Rockside Rd. Bedford Hts.	Ohio 44146		
4. Date post RU-486 complication began	n:		
1/14/22			
Event(s) (Please check all that apply):			
X Incomplete abortion	_ Adverse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Severe	bleeding		
Other serious event (specify)			
6. Duration of event: 1 Hours	Days		
7. Remarks: MAB procedure was initiated	d per FDA regimen on 12/2	2/21. Pt. called on 1	/14/22 with c/o +HSP7
US performed on 1/20/22 revealed con			
pt. did well post op.			
3. a. Name of physician who provided R	U-486 Dr. Vickery		
3. b. Physician's signature	/ Pb	M.D./	D.O.
	Date —		
end completed forms to: Stat	te Medical Board of Ohio		
Legal Depa	rtment		
30 F. Broad	St., 3 rd Floor		

Columbus, OH 43215-6127

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

	10	12	2021
	Month	Day	Year
2. Name of medical practice or facility at w Planned Parenthood of Greater Ohio	hich RU-486 was provi	ded:	
3. Address of medical practice or facility at value of the second		rided:	
4. Date post RU-486 complication began: 11/18/21			
Patient received a transfusion Severe bleed	erse reaction to RU-486	Patient hospitaliz	ed
Other serious event (specify)			
Other serious event (specify) 6. Duration of event: 1 Hours	Days		
	er FDA regimen on 10	/12/21. FU US on s s advised to seek	11/18/21 revealed care with her OBGYN
5. Duration of event: 1 Hours 7. Remarks: MAB procedure was initiated p Continuing pregnancy. Pt. preferred to continuing pregnancy. asap. a. Name of physician who provided RU-48 b. Physician's signature	er FDA regimen on 10 nue pregnancy and wa	s advised to seek	care with her OBGYN

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

7	14	2021
Month	Day	Year
ich RU-486 was provi	ded:	
io		
hich RU-486 was prov	vided:	
146		
rse reaction to RU-486	Patient hospitalize	ed
ng		
Days		
ner FDA regimen on	7/14/21 Dt colle	nd on 7/45/24 a/a liui-
royaled centing	17714/21, Ft. Call	ed on 7/15/21 c/o little
t op.	g pregnancy. Sur	gical aspiration
Dr. Vickery		
ate	8/26/2021	b.o
ale		
dical Board of Ohio		
i i i	ich RU-486 was provided in the RU-486 was provid	Month Day ich RU-486 was provided: io hich RU-486 was provided: 46 rse reaction to RU-486 Patient hospitalize ag Days Der FDA regimen on 7/14/21. Pt. calle revealed continuing pregnancy. Sur it op. Dr. Vickery

Columbus, OH 43215-6127

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	7	14	2021
	Month	Day	Year
2. Name of medical practice or facility at v	which RU-486 was provi	ded:	
Planned Parenthood of Greater C	Ohio		ericzilul
3. Address of medical practice or facility at	which RU-486 was prov	vided:	
25350 Rockside Rd. Bedford Hts., Oh 4	14146		
4. Date post RU-486 complication began: 7/15/21			
5. Event(s) (Please check all that apply):			
X Incomplete abortionAc	dverse reaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion Severe blee	eding		
Other serious event (specify)			
6. Duration of event: 1 Hours	Days		
7. Remarks: MAB procedure was initiate	d per FDA regimen or	n 7/14/21. Pt. call	ed on 7/15/21 c/o little
to no bleeding in 24 hours. US on 7/16, was performed 7/16/21; pt. did well p	/21 revealed continuin		
3. a. Name of physician who provided RU-4	Dr. Vickery		
3. b. Physician's signature <u>(Addews</u>	1 Marie	MB	_D.O
	Date		
end completed forms to: State N	Medical Board of Ohio		8
Legal Departm	ient		

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	7	8	2021
	Month	Day	Year
2. Name of medical practice or facil	lity at which RU-486 was provid	led:	
Planned Parenthood of Gre	eater Ohio		
3 Address of modical procine and	ilia		
3. Address of medical practice or fac	mity at which RU-486 was prov	ided:	
25350 Rockside Rd. Bedford Hts.	, Oh 44146		
4. Date post RU-486 complication be	egan:		
7/12/21			
5. Event(s) (Please check all that app	ıly):		
X Incomplete abortion	Adverse reaction to RU-486	Patient hospitalize	ad
		ratient nospitalize	eu .
Patient received a transfusion Sev	ere bleeding		
Other serious event (specify)			<u> </u>
6. Duration of event: 1 Hou	urs Days		
7.0			
7. Remarks: MAB procedure was into no bleeding. US on 7/14/21 rev	nitiated per FDA regimen on	7/8/21. Pt. called	d on 7/12/21 c/o little
to no bleeding. US on 7/14/21 rev called on 7/20/21 stating she had	l no bleeding/cramping after	2nd dose of mis	soprostol given. Pt.
revealed continuing pregnancy. P	t. declined aspiration and pre	eferred to continu	Je pregnancy
3. a. Name of physician who provided			programoj.
^1	own Exerce		
si si rivisician s signature	12/02/ 00-	MDy	D.O
	Date		
end completed forms to:	State Medical Board of Ohio		
	epartment		
	oad St., 3 rd Floor		
Columbi	us, OH 43215-6127		

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	7	8	2021
	Month	Day	Year
2. Name of medical practice or facility at whic	h RU-486 was provi	ided:	
Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at wh	ich RU-486 was pro	vided:	
25350 Rockside Rd. Bedford Hts., Oh 4414	16		
4. Date post RU-486 complication began:		THE PERSON	
7/12/21			
5. Event(s) (Please check all that apply):			
X Incomplete abortion Advers	e reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Severe bleeding			
Other serious event (specify)			
6. Duration of event: 1 Hours	Days		
7. Remarks: MAB procedure was initiated per to no bleeding. US on 7/14/21 revealed cor called on 7/20/21 stating she had no bleed revealed continuing pregnancy. Pt. declined	ntinuing pregnanc ling/cramping afte	y. 2nd dose of mi r 2nd dose of mis	soprostol given. Pt. o. US on 7/22/21
3. a. Name of physician who provided RU-486	Dr. Vickery		
B. b. Physician's signature	te —	8/26/2021	<u> </u>
end completed forms to: State Medi	cal Board of Ohio		

Legal Department 30 E. Broad St., 3rd Floor Columbus, OH 43215-6127



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provide	led:	5	14	21
		Month	Day	Year
2. Name of medical practi	ce or facility at which	RU-486 was provid	bhi o	
3. Address of medical prac	tice or facility at whi	ch RU-486 was provi	ided:	
25350 Porks				1146
4. Date post RU-486 comp	lication began:	.21		
5. Event(s) (Please check a	Il that apply):			
Incomplete abortion	Advers	e reaction to RU-486	Patient hospitalized	
Patient received a transfusion	on Severe bleeding			
Other serious event (specify	y)			
6. Duration of event:				
7. Remarks: May pro protocol. Pt co Ownin. Pt a	udust was illed on 6.1 wlled on 6	8.21 with c	er FOA Tec No Ideedyn h clocont	gimen per Poe 5. hs revalue inued bleedig
hab was < 7	ot ruterred		1/2100	
3. a. Name of physician wh	///	_	vacro	
8. b. Physician's signature		HOW y	(M.n) /	D.O
Send completed forms to:	State Med	ical Board of Ohio		
	Legal Department		MEDA	1115
	30 E. Broad St., 3"	d Floor	ALIG	1 7 2021
	Columbus, OH 43	215-6127	AOC	1 - 6061



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	5	7	21
	Month	Day	Year
2. Name of medical mactice or facility a			
3. Address of medical practice or facility	at which RU-486 was pr	ovided:	
25350 Rockide Rd.	bedford HB1	of umy6	
4. Date post RU-486 complication began			
5. Event(s) (Please check all that apply):			
Incomplete abortion	Adverse reaction to RU-486	Patient hospitaliz	red
Patient received a transfusion Severe byOther serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks: Mal was initial Ptcalled with @ that when when the that when the performed 1.16.21; p	ted per tra on 6.15.21. rumany	regimen us pertou surrical rost op.	on S.7.21 ned on 6.15.21 aspiration w
3. a. Name of physician who provided RI 3. b. Physician's signature	B 2/2/	N.D.	/ D.O
end completed forms to: State	e Medical Board of Ohio		
Legal Depar	tment	M	EDICAL BOARD
30 F Broad	St 3 rd Floor		

Columbus, OH 43215-6127

AUG 1 7 2021