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: 10 (Month) 21 (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:

3255 E Main St, Columbus, Ohio 43213

4. Date post RU-486 complication began:

11/23/2021

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) intrauterine debris

6. Duration of event: 1 Hours 0 Days

7. Remarks: patient called on-call RN & reported bleeding and clotting for several weeks post MAB. US on 11/23/21 showed intrauterine debris.

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

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

Date 12-2-2021

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

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) 27 (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:
3255 E. Main St. Columbus, Oh 43213

4. Date post RU-486 complication began:
7/30/21

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: MAB procedure was initiated per FDA regimen on 7/27/21. Pt. called on 7/30/21 to report little to no bleeding. US on 8/3/21 revealed continuing pregnancy. Surgical aspiration was performed 8/3/21; pt. did well post op. Incomplete abortion

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

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

Date 8/27/21

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 ORC 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:

3255 E Main St, Columbus, Ohio 43213

4. Date post RU-486 complication began: 7/19/21

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: MAB procedure was initiated per PDA regimen on 7/8/21. F/U call revealed continued pregnancy S/S. Surgical aspiration performed 7/21/21

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

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

Date 7/21/21

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

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: 6 (Month) 28 (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:
3255 E. Main St. Columbus, Oh 43213

4. Date post RU-486 complication began:
8/6/21

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: MAB procedure was initiated per FDA regimen on 6/28/21. Pt. called on 8/5/21 with + HSPT and bleeding/cramping. Pt. went to ER on 8/5/21 and had suction procedure after ultrasound revealed incomplete AB. Pt. did well post op and will follow up with her Ob/Gyn

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

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

Date 12/6/2021

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

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: 4 (Month) 21 (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:
3255 E. Main St. Columbus, OH 43213

4. Date post RU-486 complication began:
4.29.21

5. Event(s) (Please check all that apply):

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

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: ___|___ Hours _____ Days

7. Remarks: Mab procedure initiated per FDA regimen on 4.21.21. Phone call on 4.29.21 Pt states she went to ER. US on 4.29.21 revealed continuing pregnancy. Surgical aspiration was performed 5.3.21; Pt. did well post-op.

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

8. b. Physician's signature A. Lowther, MD (M.D. / D.O)

Date 6/23/21

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

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: 3 (Month) 1 (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:
3255 E. Main St Columbus, OH 43213

4. Date post RU-486 complication began:
3.29.21

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: Mab was initiated per FDA regimen on 3.1.21. US on 3.29.21 revealed intrauterine debris. Aspiration was performed 4.2.21; Pt did well post-op.

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

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

Date 6/21/2021

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