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 | 21 | 2.02.1 | |
|----------------------------------------------------------------------------------|--------------------------------------|--------------------------|-------------------|--------------------------|
| 2 Name of modical and a first | Mointh | Day | Year | |
| Name of medical practice or facility at Planned Parenthood Of G | | ided: Walling the second | | |
| Address of medical practice or factors Section 255 E Main St, Columbus | | was provided: | | |
| 4. Date post RU-486 complication be) 5. Event(s) (Please check all that app | 123/2021 | | | |
| incomplete abortionPatient received a transfusionSevere in | Adverse reaction to RU-486 bleeding | Patient hospitalized | 1 | |
| 6. Duration of event: Hours _ | Days | | | |
| 7. Remarks: Patient Cal For several weeks po debns: | ud on-call st MAB. 0) | NESTING | Hell blooding o | and Clottin trautenne |
| 8. a. Name of physician who provide 8. b. Physician's signature | d RU-486 DY, Date | Sinay 12-2-2 | _(M,010.0 0 V1 | |
| end completed forms to: | State Medical | Board of Ohio | | |
| , | Legal Department | | | |
| : | 30 E. Broad St., 3 rd Flo | or | | |
| (| 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: | readile steeps into an only make the | 27 MINISTER INCOME. | 21 |
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| | Sitis w foot when some plant we Wouth | wind a positive Day | Year |
| 2. Name of medical practice or | facility at which RU-486 was I | provided: | |
| Planned Parenthood | of Greater Ohio | designed to A | |
| 3. Address of medical practice of | r facility at which RU-486 was | provided: | |
| 3255 E. Main St. Columbus, | Oh 43213 | | |
| 4. Date post RU-486 complication | on began: | | |
| 7/30/21 | | | |
| 5. Event(s) (Please check all tha | t apply): | | |
| Incomplete abortion | Adverse reaction to RU-4 | 186Patient hospita | lized |
| Patient received a transfusion | Severe bleeding | | |
| Other serious event (specify) | | | |
| 6. Duration of event: 1 | _ Hours Days | | |
| 7. Remarks: MAB procedure v | vas initiated per FDA regimen | on 7/27/21. Pt. called | on 7/30/21 to report |
| little to no bleeding. US on 8/3/2 pt. did well post op. | 1 revealed continuing-pregnal readed stage made in the pregnal was a readed to the pregnal appear to the pregnal appear to the present accepts a manuscript present using a readed when the present accepts a reader to the pr | ncy. Surgical aspiration of the work of th | on was performed 8/3/21; |
| 8. a. Name of physician who pro | vided RU-486 Dr Rivlir | ्ट ±'राष्ट्र ।== तश्च | |
| 8. b. Physician's signature | so New sa Moted below as well actually guidelines. | Transpara Vinnais M.C | 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 BOARD

OCT 1 4 2021

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

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| Day Year provided: |
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| 486 was provided: |
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| 21 |
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| \$86 Patient hospitalized |
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| Floor |
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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

| 1. Date RU-486 was provided: | 6 | 28 | 21 |
|----------------------------------------------------|----------------------|----------------------|-----------------------|
| | Month | Day | Year |
| 2. Name of medical practice or facility at whic | h RU-486 was provi | ded: | |
| Planned Parenthood of Greater Ohio | | | |
| 3. Address of medical practice or facility at whi | ch RU-486 was prov | rided: | |
| 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 abortionAdvers | e reaction to RU-486 | Patient hospitalize | d [.] |
| Patient received a transfusion Severe bleeding | | | |
| Other serious event (specify) | , | | - Charles Selection - |
| 6. Duration of event: 1 Hours | Days | | |
| 7. Remarks: MAB procedure was initiated per Fl | DA regimen on 6/28 | /21. Pt. called on 8 | /5/21 with + HSPT |
| and bleeding/cramping. Pt. went to ER on 8/5/2 | 1 and had suction p | rocedure after ultra | sound revealed |
| incomplete AB. Pt. did well post op and will follo | | | |
| 8. a. Name of physician who provided RU-486 | Dr. McCluney | | |
| 8. b. Physician's signature | 12/6/2 | mD) | à.o |

Send completed forms to:

State Medical 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 prov | ided: | 4 | 21 | 2 | |
|--------------------------------------------------------------------------|---------------------------------------|---------------------------------------|-----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|
| | | Month | Day | Year | |
| 2. Name of medical pract | nice or facility at which R | | | | |
| 3. Address of medical pra | | | | | |
| 4. Date post RU-486 comp | lication began: | 4.29.21 | | | |
| 5. Event(s) (Please check a | | | | The state of the s | |
| Incomplete abortion | Adverse rea | action to RU-486 | Patient hospitali | zed | |
| Patient received a transfus | on Severe bleeding | | | | |
| Other serious event (specif | v) | · · · · · · · · · · · · · · · · · · · | | | |
| 5. Duration of event: | | | otensen en en Europe | | |
| 7. Remarks: Mab pro Phone call on y Nevealed cont was performed | | ted per poshe wend | DA TUGO THE ER Surgical Post-a | men on US on aspira | 1 4.21. 4.29.21 tion |
| a. Name of physician wh | o provided RU-486 | DY. U | MANTER | | |
| b. Physician's signature | Date - | 6/23/21 | MD. |) _{D.O} | |
| end completed forms to: | State Medical I | Board of Ohio | | | |
| | Legal Department | | | | |
| | 30 E. Broad St., 3 rd Floo | or | - | MEDICAL | DOAT |
| | Columbus, OH 43215- | 6127 | | MEDICAL | |
| | | | | AUG 1 | 7 2021 |

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

| 1. Date RU-486 was provided: | | 3 | Access | 21 |
|----------------------------------------------------------------|--------------------------------|-------------------|------------------|-------------|
| | | Month | Day | Year |
| 2. Name of medical practice or fa | word of | RU-486 was provid | led: Ohio | |
| 3. Address of medical practice or | facility at which | RU-486 was prov | ided: | |
| 3255 E. Main | St Cou | whis, o | 4 4321 | 3 |
| 4. Date post RU-486 complication | | | | |
| 5. Event(s) (Please check all that a | pply): | , | | |
| Incomplete abortion | Adverse re | eaction to RU-486 | Patient hospital | ized |
| Patient received a transfusion \$ | severe bleeding | | | |
| Other serious event (specify) | | | | |
| 6. Duration of event: | lours | Days | | |
| 7. Remarks: Mab was in US on 3.29.21 m was performed u | intiated percelled .2.21; | | | |
| 3. a. Name of physician who provid 3. b. Physician's signature | ed RV/488 Date | Dr. Mc | Cluney 021 | 20.0 |
| end completed forms to: | State Medical | Board of Ohio | | |
| | Department | | | |
| 30 E. E | Broad St., 3 rd Flo | oor | MED | ICAL BOARD |
| Colum | bus, OH 43215 | -6127 | | UG 1 7 2021 |