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

APR 11 2022
STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided: 2 (Month) 23 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
3/8/22

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: 2 Hours _____ Days

7. Remarks:

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

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

Date 4/5/22

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

APR 11 2022

STATE MEDICAL BOARD OF OHIO

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 2 (Month) 16 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
3/1/22

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: 2 Hours _____ Days

7. Remarks:

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

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

Date 4/5/22

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

APR 11 2022
STATE MEDICAL BOARD OF OHIO

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 2 (Month) 5 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
2/11/22

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: 2 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. [illegible]

8. b. Physician's signature _____ MD/DO

Date 4/1/22

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

APR 11 2022

STATE MEDICAL BOARD OF OHIO

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
2/21/22

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: 3 Hours _____ Days

7. Remarks:

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

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

Date 4/1/22

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) 8 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
1/12/22

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: _____ Hours _____ Days

7. Remarks:

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

8. b. Physician's signature _____ MD/DO

Date 2/8/22

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

FEB 17 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

APR 11 2022

STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided: 1 (Month) 5 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
1/12/22

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

Y 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:

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

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

Date 4/5/22

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) 29 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
1/7/21

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

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

X Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: _____ Hours 2 Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. K61sy

8. b. Physician's signature [signature] (M)D/DO

Date 2/8/22

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

FEB 17 2022

STATE MEDICAL BOARD OF OHIO

Prescribed: S/--/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) 28 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
12/30/21

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: 6 Hours _____ Days

7. Remarks:

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

8. b. Physician's signature [signature] MD/DO

Date 2/8/22

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

FEB 17 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: 11 (Month) 18 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
11/26/21

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

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

X Patient received a transfusion X Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 5 Hours _____ Days

7. Remarks:

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

8. b. Physician's signature _____ MD/DO

Date 1/28/22

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

FEB 17 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: 11/17/21 (Month / Day / Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
12/17/21

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: 3 Hours _____ Days

7. Remarks:

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

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

Date 1/12/22

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: 11 (Month) 17 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
11/19/21

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: 2 Hours _____ Days

7. Remarks:

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

8. b. Physician's signature _____ MD / DO

Date 11/23/21

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

DEC 09 2021

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: 11 (Month) 10 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
11/11/21

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:

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

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

Date 1/5/22

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

JAN 13 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: 10 (Month) 22 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
10/24/21

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

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

___ Patient received a transfusion X Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 3 Hours _____ Days

7. Remarks:

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

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

Date 12/3/21

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

DEC 09 2021
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: 10 (Month) 15 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
10/27/21

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: 2 Hours _____ Days

7. Remarks:

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

8. b. Physician's signature _____ MD / DO

Date 12/3/21

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

DEC 09 2021
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: 10 (Month) 14 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
11/10/21

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: 2 Hours _____ Days

7. Remarks:

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

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

Date 11/23/21

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

DEC 09 2021
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: 10 (Month) 13 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
10/28/21

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

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

___ Patient received a transfusion X Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks:

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

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

Date 11/11/21

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

DEC 09 2021
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: 10 (Month) 8 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
11/10/21

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: 3 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. [illegible]

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

Date 12/3/21

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

DEC 09 2021

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: 10 (Month) 6 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
10/21/21

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: 2 Hours _____ Days

7. Remarks:

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

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

Date 1/5/2022

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

JAN 13 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: 10 (Month) 5 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood SW Ohio

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave Cincinnati, OH 45219

4. Date post RU-486 complication began:
10/20/21

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: 2 Hours _____ Days

7. Remarks:

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

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

NOV 09 2021

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: 9 (Month) 2 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
9/9/21

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: 2 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. [illegible]

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

Date 10/6/2021

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

MEDICAL BOARD
OCT 19 2021

Prescribed: S/--/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: 8 (Month) 25 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
9/3/21

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

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

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks:

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

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

Date 10/6/2021

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

JAN 13 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: 8 (Month) 17 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
8/23/21

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: 2 Hours _____ Days

7. Remarks:

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

8. b. Physician's signature Kalsy (M.D./D.O.)

Date 9/21/21

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

MEDICAL BOARD
SEP 28 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: 6 (Month) 24 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

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: 3 Hours _____ Days

7. Remarks:

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

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

Date 9/8/2021

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

SEP 13 2021
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: 6 (Month) 23 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
7/10/21

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: 2 Hours _____ Days

7. Remarks:

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

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

Date 7/23/21

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

MEDICAL BOARD
AUG 0 2 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: 6 (Month) 17 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
6/24/21

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: 2 Hours _____ Days

7. Remarks:

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

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

Date 7/15/21

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

MEDICAL BOARD
JUL 26 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: 6 (Month) 2 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
7/13/21

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: 3 Hours _____ Days

7. Remarks:

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

8. b. Physician's signature _____ (MD/DO)

Date 7/23/21

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

MEDICAL BOARD
AUG 02 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) 20 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
7/15/21

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) _____

6. Duration of event: 3 Hours _____ Days

7. Remarks:

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

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

Date 7/23/21

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

MEDICAL
AUG 02 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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
5/18/21

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: 2 Hours _____ Days

7. Remarks:
completed surgically

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

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

Date 5/20/21

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

MEDICAL BOARD
JUN 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) 6 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
6/22/21

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: _____ Hours ___1___ Days

7. Remarks:

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

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

Date 7/7/21

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

MEDICAL BOARD
JUL 12 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) 6 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
6/13/21

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

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

X Patient received a transfusion X Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: _____ Hours 27 Days

7. Remarks:

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

8. b. Physician's signature _____ (MD/DO)

Date 7/27/21

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

MEDICAL BOARD
SEP 28 2021

Prescribed: S/--/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: 4 (Month) 22 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
6/2/21

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: 3 Hours _____ Days

7. Remarks:

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

8. b. Physician's signature _____ MD / DO

Date 6/10/21

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

MEDICAL BOARD
JUN 21 2021

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

MEDICAL BOARD
JUN 23 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: 4 (Month) 16 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
6/1/21

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: _____ Hours 2 Days

7. Remarks:

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

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

Date 6/17/21

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: 4 (Month) 8 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood Southwest Ohio

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cincinnati, 45219

4. Date post RU-486 complication began:
5/28/21

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: _____ Hours 2 Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. [illegible]

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

Date 6/10/21

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

MEDICAL BOARD
JUN 21 2021

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

MEDICAL BOARD

JUN 0 2 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: 4 (Month) 6 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
5/20/21

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: 3 Hours _____ Days

7. Remarks:
Completed surgically

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

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

Date 5/25/21

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: 3 (Month) 3 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

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

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

☒ Incomplete abortion / failed ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 _____

8. b. Physician's signature _____ MD / DO

Date 4/9/21

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

MEDICAL BOARD
APR 21 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: 2 (Month) 5 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
2/11/21

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: 2 Hours _____ Days

7. Remarks:

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

8. b. Physician's signature _____ MD/DO

Date 2/24/21

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

MEDICAL BOARD
MAR 08 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: 1 (Month) 22 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
3/2/21

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: 3 Hours _____ Days

7. Remarks:
completed surgically

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

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

Date 4/6/21

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

MEDICAL BOARD
APR 21 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: 1 (Month) 5 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
2/1/21

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: 3 ~~2~~ Hours _____ Days

7. Remarks:

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

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

Date 4/30/21

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

MEDICAL BOARD
APR 05 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: 12 (Month) 29 (Day) 20 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:

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: _____ Hours 20 Days

7. Remarks:

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

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

Date 4/13/21

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

MEDICAL BOARD
APR 21 2021

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