

APR 1 1 2022

(Required pursuant to R.C. 2919.123)

STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided:	2	23	22
	Month	Day	Year
2. Name of medical practice or facility: Planned Parenthood	1	ded:	
3. Address of medical practice or facility	at which RU-486 was prov	rided:	
2314 Auburn Aug	. ana, of	45219	
4. Date post RU-486 complication began $3/8/22$	n:		
5. Event(s) (Please check all that apply):			
	_ Adverse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusionSevere	bleeding		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:			
Y .,			
8. a. Name of physician who provided F		Da Kalaz	
8. b. Physician's signature	Maly 4/	(M.D.	/D.O
	Date 4/	5/22	
Send completed forms to: Sta	te Medical Board of Ohio		
Legal Depa	artment		
	d St., 3 rd Floor		
Columbus,	OH 43215-6127		



APR 1 1 2022

(Required pursuant to R.C. 2919.123)

STATE MEDICAL BOARD OF CHIC

1. Date RU-486 was provid	ed:	2	16	22
		Month	Day	Year
2. Name of medical practic	^	ch RU-486 was provi	ded:	
3. Address of medical pract	ice or facility at w	hich RU-486 was pro	vided:	
2314 Auburr	Ave. C	ina, of	45219	
4. Date post RU-486 compli				
5. Event(s) (Please check all	that apply):			
L'Incomplete abortion	Adve	rse reaction to RU-486	Patient hospitalized	d
Patient received a transfusio	n Severe bleedii	ng		
Other serious event (specify)				
6. Duration of event:	2 Hours	Days		
7. Remarks:				
	`			
8. a. Name of physician who	provided RU-486		Dr. 1665	
8. b. Physician's signature			my (MD)	D.O.
	1	Date4/	5/22	
Send completed forms to:	State Me	dical Board of Ohio		
	Legal Departmen			
	30 E. Broad St., 3	3 rd Floor		
	Columbus, OH 4	3215-6127		



APR 1 1 2022

(Required pursuant to R.C. 2919.123)

STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided:	2	5	22
	Month	Day	Year
2. Name of medical practice or facility a Planned Parenthood		ded:	
3. Address of medical practice or facility	at which RU-486 was prov	vided:	
2314 Auburn Aue.	ana, of	45219	
4. Date post RU-486 complication began $2(11/22)$): 		
5. Event(s) (Please check all that apply):			
4Incomplete abortion	_Adverse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusionevere	bleeding		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:			
No.			
\			
8. a. Name of physician who provided R	U-486 Dr	fusik	
8. b. Physician's signature	a	MD	D.O.
	DateU	1/22	
Send completed forms to: Stat	e Medical Board of Ohio		
Legal Depa	rtment		
	St., 3 rd Floor		
Columbus,	OH 43215-6127		



(Required pursuant to R.C. 2919.123)

APR 1 1 2022

To be completed by the physician who provided RU-485

STATE MEDICAL BOARD OF OHIO

. Date RU-486 was provided:	1	13	22
	Month	Day	Year
Planned Parenthood	hich RU-486 was prov	ided:	
3. Address of medical practice or facility at	which RU-486 was pro	vided:	
2314 Auburn Aue.	ana, of	45219	
Date post RU-486 complication began: $2/21/22$			
. Event(s) (Please check all that apply):			
Ad	verse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusionSevere blee	ding		
Other serious event (specify)			
. Duration of event:3 Hours	Days		
. Remarks:			
ν,			
a. Name of physician who provided RU-4	86	Do Ponsh	
b. Physician's signature	Date 4	11/22	'D.O
end completed forms to: State N	Medical Board of Ohio		

Legal Department

30 E. Broad St., 3rd Floor



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		5	22
	Month	Day	Year
2. Name of medical practice or facility of the Planned Parentho.	1	rided:	
3. Address of medical practice or face		-	
4. Date post RU-486 complication be	egan:		
5. Event(s) (Please check all that app	ly):		
Incomplete abortion	Adverse reaction to RU-486	Patient hospitalized	I
Patient received a transfusion Sev	ere bleeding		
Other serious event (specify)			
6. Duration of event:Ho	urs Days		
7. Remarks:			
8. a. Name of physician who provided	d RU-486	Dr. K6/1	3
8. b. Physician's signature	Maley Date	18/22 MD/1	D.O
Send completed forms to:	State Medical Board of Ohio		
Legal De	epartment		
	oad St., 3 rd Floor		



(Required pursuant to R.C. 2919.123)

APR 1 1 2022

To be completed by the physician who provided RU-485

STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided:	/	5	22
	Month	Day	Year
2. Name of medical practice or face Planned Parentho	1	ided:	
3. Address of medical practice or fa	cility at which RU-486 was pro	ovided:	
2314 Auburn A	u. ana, of	45219	
4. Date post RU-486 complication b	egan:		
5. Event(s) (Please check all that ap	ply):		
4Incomplete abortion	Adverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Se	evere bleeding		
Other serious event (specify)			
6. Duration of event: H	ours Days		
7. Remarks:			
8. a. Name of physician who provide	ed RU-486	Dr Klosy	
8. b. Physician's signature	Date	122 (MD)	٠
Send completed forms to:	State Medical Board of Ohio		
•	Department		
	road St., 3 rd Floor		
	bus, OH 43215-6127		



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	12	29	2/
	Month	Day	Year
2. Name of medical practice or facility at which Planned Parenthood	RU-486 was provid	ed:	
3. Address of medical practice or facility at which	RU-486 was prov	ided:	
2314 Auburn Aue. av	na, of	45219	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Incomplete abortionAdverse	reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe bleeding			
Other serious event (specify)			William to be a second
•	Days		
Other serious event (specify)	Days		
Other serious event (specify)6. Duration of event: Hours2	Days		
Other serious event (specify)6. Duration of event: Hours2	Days		
Other serious event (specify) 6. Duration of event: Hours Z 7. Remarks:	_Days	r. K6/	(y

Legal Department

30 E. Broad St., 3rd Floor



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:		2 9	21
2. Name of medical practice or facility at w	Month hich RU-486 was prov	Day rided:	Year
3. Address of medical practice or facility at 2314 Auburn Au.			
4. Date post RU-486 complication began:			
Patient received a transfusion		Patient nospitalize	ed
Other serious event (specify)			
7. Remarks:	Days		
3. a. Name of physician who provided RU-4 3. b. Physician's signature	86	Dr. Kalsu	
3. b. Physician's signature	Date 2/8	2/22 (Md)	<u> </u>

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

	18	21	
Month n RU-486 was provid	Day ded:	Year	
e reaction to RU-486	Patient hospitalize	ed	
Days			
2 / /28 te //28	elv.	D.O.	**************
	ch RU-486 was provided in RU-486 was provided in RU-486 was provided in RU-486.	Pays Provided: Ch RU-486 was provided: Ch RU-486 was provided: Ch RU-486 was provided: Patient hospitalized: Pays Pays	Pays President RU-486 was provided: Procedure of the reaction to RU-486 — Patient hospitalized Pays Pays Pays

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:		1/17/2	1	
	Moi	nth	Day	Year
2. Name of medical practice or facility at Planned Parenthood	which RU-486	was provided:		
3. Address of medical practice or facility a	t which RU-486	was provided:		
2314 Auburn Aus.	ana,	04 45.	219	
4. Date post RU-486 complication began:				
12/17/21		· .		
5. Event(s) (Please check all that apply):			and the second s	
Uncomplete abortionA	Adverse reaction to	o RU-486 Patie	ent hospitalized	
Patient received a transfusion Severe ble Other serious event (specify)	-			
6. Duration of event:3Hours _	Days			
7. Remarks:				
			-	maga:
N.				
8. a. Name of physician who provided RU-	-486	Dr. 1	(6/54	
8. b. Physician's signature	Date —	1/12/22	MDIDO	
Send completed forms to: State	Medical Board	of Ohio		
Legal Departi	ment			
30 E. Broad S	it., 3 rd Floor			

Columbus, OH 43215-6127

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:	_//	17	2/
	Month	Day	Year
2. Name of medical practice or facility Planned Parenthood		vided:	
3. Address of medical practice or facili	ty at which RU-486 was pr	ovided:	
2314 Auburn Aus	. ana, of	45219	
4. Date post RU-486 complication begans $11/19/21$	en:		
5. Event(s) (Please check all that apply)			
and the state of t	· .		
	Adverse reaction to RU-486	Patient hospitalized	†
Patient received a transfusion Severe	bleeding		
Other serious event (specify)			Miletorranguagassara.
5. Duration of event: 2 Hours	Days		
7. Remarks:			
. a. Name of physician who provided F	RU-486	r. 66/57	
. b. Physician's signature	- Joed C.	MD/C	20
	Date	13/21	
end completed forms to: Sta	te Medical Board of Ohio		
Legal Depa			
	l St., 3 rd Floor		
	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:	11	10	2-1	_
	Month	Day	Year	_
2. Name of medical practice or facility a	t which RU-486 was provi	ded:		
Planned Parenthood	_			
3. Address of medical practice or facility	at which RU-486 was pro	vided:		
2314 Auburn Aus.	ana, of	45219		
4. Date post RU-486 complication began:				
12/1/24				
5. Event(s) (Please check all that apply):				
	Adverse reaction to RU-486	Patient hospitalized		
Patient received a transfusion Severe bl	eeding			
Other serious event (specify)				
				-
6. Duration of event: Hours _	Days			
7. Remarks:				_
,				
. a. Name of physician who provided RU-	486	line		
. b. Physician's signature	Mill.	MOLD	0	
	Date	4		
end completed forms to: State	Medical Board of Ohio			
Logal Danasta				

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

JAN 13 2022

STATE MEDICAL BOARD OF OHIS



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	10	27	7,
	Month	Day	Z / Year
2. Name of medical practice or facility Planned Parenthood	/	led:	
3. Address of medical practice or facilit	ry at which RU-486 was prov	ided:	
2314 Auburn Au	. Cina, of	45219	
4. Date post RU-486 complication bega	in:		-
10/24/21	1		
5. Event(s) (Please check all that apply)	:		
Incomplete abortion	_ Adverse reaction to RU-486	Patient hospitalized	d
Patient received a transfusion 🔑 Severe	bleeding		
Other serious event (specify)			
6. Duration of event: 3 Hours	Days		1730
7. Remarks:			
		444	
8. a. Name of physician who provided R	1U-486 De Pin	Sah	
8. b. Physician's signature	6/-	MB/	0.0
	Date —	12/3/21	
Send completed forms to: Star	te Medical Board of Ohio		
Legal Depa	rtment		

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

DEC 0.9 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	10	15	Z/
	Month	Day	Year
2. Name of medical practice or facility	at which RU-486 was provi	ded:	
Planned Parenthood			
3. Address of medical practice or facility	at which RU-486 was prov	vided:	
2314 Auburn Aus	ana, of	45219	
4. Date post RU-486 complication began	1:		
10/27/21			
5. Event(s) (Please check all that apply):			
Incomplete abortion	_Adverse reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe i	pleeding		
Other serious event (specify)			
5. Duration of event: 2 Hours	Days		
7. Remarks:			
a. Name of physician who provided RI	J-486	Floor	
b. Physician's signature	9-	CMD/	0.0
	Date ————	12/3/21	
end completed forms to: State	Medical Board of Ohio		
Logal Donar			

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 provided:	/0	14	21
	Month	Day	Year
2. Name of medical practice or facility a Planned Parenthood		ded:	
3. Address of medical practice or facility 2314 Auburn Au.			
4. Date post RU-486 complication began: $1/1/2$			
5. Event(s) (Please check all that apply):			
Incomplete abortion	Adverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe bl	eeding		
Other serious event (specify)			
5. Duration of event:2 Hours	Days		
7. Remarks:	-		
î			
a. Name of physician who provided RU-	-486 <u>, L</u>	Dr. talsy	
b. Physician's signature	Date 11/23/	Z MD/D	0
end completed forms to: State	Medical Board of Ohio		
Legal Departr	ment		
20 5 0 10	t., 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:	10	/3	21
2. Name of medical practice or facility at which Planned Parenthood	Month n RU-486 was pro	Day vided:	Year
3. Address of medical practice or facility at which 2314 Auburn Au. (1)			
4. Date post RU-486 complication began: / 0 しょり と			
5. Event(s) (Please check all that apply):			
Incomplete abortion Adverse	reaction to RU-486	Patient hospitalize	d
Patient received a transfusionSevere bleeding			
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:		300	
B. a. Name of physician who provided RU-486		Kalin	
B. b. Physician's signature	Mar	141/21 M.D.11	20
end completed forms to: State Medica	al 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 provided:	_/0	8	H
	Month	Day	Year
2. Name of medical practice or facility Planned Parenthood		rovided:	
3. Address of medical practice or facility	y at which RU-486 was	provided:	
2314 Auburn Aug			
4. Date post RU-486 complication began $11/13/2$	1:		
5. Event(s) (Please check all that apply):			
Lincomplete abortion	_Adverse reaction to RU-48	6 Patient hospitalize	d
Patient received a transfusion Severe	bleeding		
Other serious event (specify)			-
6. Duration of event: Hours	Days		
7. Remarks:			
•			
B. a. Name of physician who provided RI	J-486	De Gensel	
B. b. Physician's signature		M.D. /	20
	Date12/3/		
end completed forms to: State	e Medical Board of Ohio)	
Legal Depar	tment		
30 E. Broad	St., 3 rd Floor		
Columbus, C	OH 43215-6127		

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



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	_/0	6	21
	Month	Day	Year
2. Name of medical practice or facility Planned Parenthood	at which RU-486 was provi	ded:	
3. Address of medical practice or facility	at which RU-486 was pro	vided:	
2314 Auburn Aug			
4. Date post RU-486 complication began	1:		
13/21/21			
5. Event(s) (Please check all that apply):			
Incomplete abortion	Adverse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Severe t	oleeding .		
Other serious event (specify)			
6. Duration of event: 2 Hours	Days		
7. Remarks:			
-			
B. a. Name of physician who provided RU	Λ -		
<i>γ</i> Λ		bur sahery	
B. b. Physician's signature	Date 1/5/20	M.D./	0.0
end completed forms to: State	Medical Board of Ohio	2	
Legal Depart	ment		
30 E. Broad S	St., 3 rd Floor		

Columbus, OH 43215-6127

JAN 13 2022



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:		5	21
	Month	Day	Year
2. Name of medical practice or facility at Planned Parent hood		·d:	
3. Address of medical practice or facility at 2314 Aubur Am			19
4. Date post RU-486 complication began:			
10/20/21			
5. Event(s) (Please check all that apply):			
A	dverse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Severe ble	eding		
Other serious event (specify)			
6. Duration of event:2_ Hours	Days		
7. Remarks:	1	*****	
3. a. Name of physician who provided RU-	486 <u>Dr</u>	Kalsy	
3. b. Physician's signature	Maly	(M.D)	'D.O
	Date		
Send completed forms to: State I	Medical Board of Ohio		
Legal Departn	nent		
30 E. Broad St	., 3 rd Floor		

Columbus, OH 43215-6127

NOV 09 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	9	2	21
	Month	Day	Year
2. Name of medical practice or facility at which Planned Parenthood	RU-486 was provid	led:	
3. Address of medical practice or facility at which	ch RU-486 was prov	ided:	
2314 Auburn Aus. a)	na, of	45219	
4. Date post RU-486 complication began: 9/9/14			
5. Event(s) (Please check all that apply):			
Adverse	reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe bleeding			
Other serious event (specify)			
6. Duration of event: Hours	Days	and the second s	
7. Remarks:			
B. a. Name of physician who provided RU-486), Com show	1
B. b. Physician's signatureDat	ymsa (1)	6/20y	D.O
end completed forms to: State Medic	cal Board of Ohio		
land Daniel			

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

OCT 1 9 2021



(Required pursuant to R.C. 2919.123)

		0		
1. Date RU-486 was prov	/ided:	Month	25	21
2. Name of medical prac			Day ided:	Year
4. Date post RU-486 com	olication began:			
5. Event(s) (Please check				
Incomplete abortion		ection to RU-486	Patient hospitalized	
Patient received a transfus	ion Severe bleeding			
Other serious event (specif	у)			_
6. Duration of event:	2 Hours	Days		
7. Remarks:				
8. a. Name of physician wh	o provided RU-486	Dr. 6	involutar	
8. b. Physician's signature	Date -	00	MD/D.	0
Send completed forms to:	State Medical I	Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd Floo		I MAL	3 2022
	Columbus, OH 43215-	6127	STATE MEDICA	L BOARD OF O



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	8	17	N
	Month	Day	Year
2. Name of medical practice or facility at whic	h RU-486 was prov	vided:	
Planned Parenthood			
3. Address of medical practice or facility at whi	ich RU-486 was pro	ovided:	
2314 Auburn Aue. a	na, of	45219	
4. Date post RU-486 complication began:			
8/23/2	,		
5. Event(s) (Please check all that apply):			
Incomplete abortion Advers	e 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:			
١.			
8. a. Name of physician who provided RU-486		Dr. Kalsy	
8. b. Physician's signature Da	Maly g	/21/21 M.D/15	0.0
Send completed forms to: State Medi			

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD SEP 2 8 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u> </u>	24	21
	Month	Day	Year
2. Name of medical practice or facility at a Planned Parenthood	which RU-486 was pro	ovided:	
3. Address of medical practice or facility at 2314 Auburn Au.	e serveral programme and a president programme.		and and and and and and and and and and
4. Date post RU-486 complication began: 귀 3 カ ユ			
5. Event(s) (Please check all that apply):			
Incomplete abortion Ad	iverse reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe blee	ding		
Other serious event (specify)			****
5. Duration of event: 3 Hours _	Days		
7. Remarks:			
,			
a. Name of physician who provided RU-4	86 <u>Dr</u>	berschap	
b. Physician's signature	maj	MD/ 812021	D.O.
nd completed forms to: State M	ledical Board of Ohio		
Legal Departme	ent		
30 E. Broad St.,	3 rd Floor		



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	6	23	21
	Month	Day	Year
2. Name of medical practice or facility at which R Planned Parenthood	U-486 was pro	vided:	
3. Address of medical practice or facility at which	RU-486 was pr	ovided:	
2314 Auburn Aus. an	a, of	45219	
4. Date post RU-486 complication began:			
7/10/21			
5. Event(s) (Please check all that apply):			
Adverse re	eaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe bleeding			
Other serious event (specify)			
6. Duration of event: 2 Hours	Days		
7. Remarks:			
V.			
8. a. Name of physician who provided RU-486		Dr. Kalsus	
	Maly	1/3 2/2 M.D)	D.O
Date		100/01	

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



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	_6		17	21
	Month		Day	Year
2. Name of medical practice or facility	71	s provided:		
Planned Parenthood	<u>L</u>			
3. Address of medical practice or facilit	y at which RU-486 w	as provided:		
2314 Auburn Au	. ana, a	of 45.	219	
4. Date post RU-486 complication bega しん2サイン	n:			
5. Event(s) (Please check all that apply)	:			
4 Incomplete abortion	_ Adverse reaction to RU	J-486 Patie	nt 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 R	U-486	Dr.	Bornes	
8. b. Physician's signature			MOVO	0
	Date	115/21		
Send completed forms to: Stat	e Medical Board of	Ohio		
Legal Depa	rtment		MEI	DICAL BOARD
20 E Propo	C+ 2rd Flags			

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

JUL 26 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	_6	2	21
	Month	Day	Year
2. Name of medical practice or facility Planned Parenthoo		ded:	
3. Address of medical practice or facili	ty at which RU-486 was prov	rided:	
2314 Auburn Au			
4. Date post RU-486 complication beg. イカオ	an:		
5. Event(s) (Please check all that apply):		
	Adverse reaction to RU-486	Patient hospitalized	i
Patient received a transfusion Severe	e bleeding		
Other serious event (specify)			
6. Duration of event:3 Hours	s Days		
7. Remarks:			
B. a. Name of physician who provided I		Kalsy	
b. Physician's signature	Pate 71	123/21 MD.10	0.0
end completed forms to: Sta	te Medical Board of Ohio		
Legal Depa	artment		
30 E. Broad	d St., 3 rd Floor		NEDICAL 3

Columbus, OH 43215-6127

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

MEDICAL KOARD

AUU 0 2 2021



(Required pursuant to R.C. 2919.123)

1. Date RU-486 was prov	ided:	-	20	2.
		Month	20 Day	Year
2. Name of medical pract Planned Par		RU-486 was provi		Tedi
3. Address of medical prac	ctice or facility at which	h RU-486 was pro	vided:	
2314 Aubur				
4. Date post RU-486 comp	lication began:			
5. Event(s) (Please check a	Il that apply):			
$ ot\!$	Adverse	reaction to RU-486	Patient hospitalized	1
Patient received a transfusion	on Severe bleeding			
Other serious event (specify)			
6. Duration of event:	3_Hours	_ Days		
7. Remarks:				
3. a. Name of physician who	provided RU-486		Dr Penal	{
3. b. Physician's signature			MDVI	20
	Date	7/23/21		
end completed forms to:	State Medica	Board of Ohio		
	Legal Department		IN.	EDICA: ME
	30 E. Broad St., 3 rd Fl	oor		AUG 0 2 2021
	Columbus, OH 4321	5-6127		MUU U Z ZUZI



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	3		
	Month	14	
2. Name of medical practice or facility a		Day	Year
Planned Parenthood	which ku-486 was pr	ovided:	
3. Address of medical practice or facility	at which RU-486 was p	rovided:	
2314 Auburn Aue.	ana, of	45219	
4. Date post RU-486 complication began らしい としゅうしゅうしゅうしゅう			
5. Event(s) (Please check all that apply):			
Incomplete abortion	Adverse reaction to RU-486	Patient hospita	lized
Patient received a transfusion Severe b	leeding		
Other serious event (specify)			
Duration of event: Hours _	Days		
1. Remarks: unplaced Surpically			
a. Name of physician who provided RU-	486	Pemah	
b. Physician's signature		MA	/D.O
	Date	5/20/21	
nd completed forms to: State	Medical Board of Ohio		
Legal Departr	nent	•	MEDICAL BOARD
30 E. Broad St	., 3 rd Floor	V	JUN 1 4 2021
Columbus, OH	1 42215-6127		JUN 1 4 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	\$	<u></u>	\mathcal{U}
	Month	Day	Year
2. Name of medical practice or facility at	which RU-486 was provi	ded:	
Planned Parenthood	•		
3. Address of medical practice or facility a	turbish BIL 485 was man		
	· · · · · · · · · · · · · · · · · · ·		
2314 Auburn Aue.	ana, of	45219	
4. Date post RU-486 complication began:			
6/22/1			
5. Event(s) (Please check all that apply):			
Incomplete abortionA	dverse reaction to RU-486	Patient hospitalized	4
			• ·
Patient received a transfusion Severe blee	eding		
Other serious event (specify)			
	_		,
6. Duration of event: Hours	Days		
7. Remarks:			
\.			
a. Name of physician who provided RU-4	7.	. Kalsing	
b. Physician's signature	Milley	(M.D.)	20
	Date	17/24	
end completed forms to: State N	Medical Board of Ohio		

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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JUL 12 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:		/	37
i Date No 400 was provided.	Month	<u>(</u>	
		Day	Year
2. Name of medical practice or facility at whi	ch RU-486 was provid	ded:	
Planned Parenthood			
3. Address of medical practice or facility at wh	nich RU-486 was prov	vided:	
2314 Auburn Aus. C	ina, of	45219	
4. Date post RU-486 complication began:			
6/13/21			
5. Event(s) (Please check all that apply):			
Alncomplete abortion Adver	se reaction to RU-486	Patient hospitalize	ed
Y Patient received a transfusion	g		
Other serious event (specify)			
6. Duration of event: Hours2	7 Days		
7. Remarks:			
N.			
3. a. Name of physician who provided RU-486	<i>i</i>),	- Kisten	
	Mala		
8. b. Physician's signature	7/2	7/2/ (M.D.)	<u> </u>
D	ate		

Send completed forms to:

State Medical Board of Ohio

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Columbus, OH 43215-6127

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SEP 2 8 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	4	2.2	21
	Month	Day	Year
2. Name of medical practice or facility at Planned Parenthood	which RU-486 was provid	ded:	
3. Address of medical practice or facility at	which RU-486 was prov	îded:	
2314 Auburn Aus.	ana, of	45219	
4. Date post RU-486 complication began:			
6 2121			
5. Event(s) (Please check all that apply):			
Incomplete abortionAd	lverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe blee	ding		
Other serious event (specify)			***************************************
5. Duration of event:	Days		
7. Remarks:			
A Maria of the Art			
a. Name of physician who provided RU-4	//.	Kalin	
b. Physician's signature	Malyn Date Mal	to 10/10/2	
and completed forms to: State M	edical Board of Ohio	/ 1 1	

Prescribed: \$/--/2011, Rev. 12/13/12

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JUN 2 1 2021



MEDICAL BOARD JUN 2 3 2021

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		4	16	V
		Jonth	Day	Year
2. Name of medical practice or face Planned Parentha		6 was prov	rided:	
3. Address of medical practice or fa				
2314 Auburn A	u. ana	, 041	45219	
4. Date post RU-486 complication b	egan:			
6/1/4				
5. Event(s) (Please check all that ap	ply):			
Incomplete abortion	Adverse reaction	to RU-486	Patient hospitalized	
			ratione nospitalized	1
Patient received a transfusionSe	vere bleeding			
Other serious event (specify)				
6. Duration of event: Ho	ours 2 Days			
	- Days			
7. Remarks:				
\\				
3. a. Name of physician who provide	d_RU-486	Da_	Swood	
b. Physician's signature			W/1	3.0
	Date ——		4/17/21	
end completed forms to:	State Medical Board	of Ohio		
Legal Do	epartment			
30 E. Br	oad St., 3 rd Floor			



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	4	8	7
2 Name of modical and the College	Month	Day	Year
2. Name of medical practice or facility at	which RU-486 was provid	ded:	
Planned Parent	hood South	west Ohio	
3. Address of medical practice or facility at	Which RU-486 was prov	ided:	
2314 Aubun Av	4. Cina man	ti, 45219	
4. Date post RU-486 complication began:			
5/28/4			
5. Event(s) (Please check all that apply):			
Ancomplete abortionAn	dverse reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe blee	eding		
Other serious event (specify)			
6. Duration of event: Hours	2_Days		
7. Remarks:			
8. a. Name of physician who provided RU-4	186	· binr	
8. b. Physician's signature	X-	QB/	D.O.
	Date	0/2/	

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MEDICAL BOARD JUN 2 1 2021

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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	6	24
	Month	Day	Year
2. Name of medical practice or facility at	which RU-486 was prov	ided:	. 601
Planned Parenthood		ŧ	
3. Address of medical practice or facility a	at which DII ACC		
2314 Auburn Aus.	ana, of	45219	
4. Date post RU-486 complication began:			
5/20/21			
5. Event(s) (Please check all that apply):			
Incomplete abortion	duarea raading to DU tag		
^	dverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe ble	eding		
Other serious event (specify)			
5. Duration of event: Hours	Davs		
7. Remarks:			
Completed Surjectedy			
Compour - g - g			
V			
a. Name of physician who provided RU-4	186	r Pick	
b. Physician's signature	01/		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Date 5/25/2	M.D./D	
	Date 5/3/2		
	ledical Board of Ohio		
Legal Departm			
30 E. Broad St.,			
Columbus, OH	43215-6127		

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



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	3	3	21
	Month	Day	
2. Name of medical practice or facility at wh	nich RU-486 was provid	ed:	Year
Planned Parenthood	provid		
The state of the s			
3. Address of medical practice or facility at w	hich RU-486 was provi	ded:	
2314 Auburn Aus. C	ana, of	45219	
1. Date post RU-486 complication began:			
4/6/21			
. Event(s) (Please check all that apply):			
2 Incomplete abortion / FailedAdver			
Adver	rse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severa blooding			
Patient received a transfusion Severe bleedin	ng		
Patient received a transfusion Severe bleedin Other serious event (specify)			-
Other serious event (specify)			
Other serious event (specify)			
Other serious event (specify) Duration of event: Hours			
Other serious event (specify)			
Other serious event (specify) Duration of event: Hours			
Other serious event (specify) Duration of event: Hours			
Other serious event (specify) Duration of event: Hours Remarks:	Days		
Other serious event (specify) Duration of event: Hours Remarks:	Days		
Other serious event (specify) Duration of event: Hours Remarks:	Days	\\\ \/\ \\\\ \\\\ \\\\\ \\\\\\\\\\\\\\	Ω

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30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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APR 2 1 2021



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:			
provided.	2	<u> </u>	21
2. Name of medical program on facility	Month	Day	Year
2. Name of medical practice or facility a Planned Parenthood	t which RU-486 was prov	vided:	
3. Address of medical practice or facility	at which RU-486 was pro	wided:	
2314 Auburn Aus.	ana, of	45219	
4. Date post RU-486 complication begans			
5. Event(s) (Please check all that apply):			
✓ Incomplete abortion	Adverse reaction to RU-486	Patient nospitalize	d
Patient received a transfusion Severe bi	eeding		
Other serious event (specify)			-
6. Duration of event:2 Hours _	Days		
7. Remarks:			
٠,			
B. a. Name of physician who provided RU-	486 <u>Dr.</u>	THE PARTY OF THE P	
B. b. Physician's signature		MD/1	0.0
	Date	126/21	
end completed forms to: State I	Medical Board of Ohio		
Legal Departn	nent		MED.
30 E. Broad St	., 3 rd Floor		MEDICAL BOA

Columbus, OH 43215-6127

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

Month 186 was provid -486 was provi	ded:	Z (Year
-486 was provi	ded:	
0+1	c. 10	
, 01	45219	
on to RU-486	Patient hospitalized	
ys	,	
D.	line	
	MD/D	0
41	16/21	

send completed forms to:

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:		
2. Name of medical practice as 5	Month Day Year	
Planned Parenth	acility at which RU-486 was provided:	
	facility at which NU 486 was provided:	
2314 Auburn A	tur. ana, of 45219	
4. Date post RU-486 complication	began:	
5. Event(s) (Please check all that a		
∠ Incomplete abortion	Adverse reaction to RU-486 Patient hospitalized	
Patient received a transfusion S		
	evere bleeding	
Other serious event (specify)		ŀ
6. Duration of event: 3	lours Days	
7. Remarks:		
,		
a. Name of physician who provide	ed RILAGE 1) P. 17	
	Onr	
· U. FIIVSICIAN S SIGNATURA	MD/DO	
. b. Physician's signature	Date 7\30\2\	
	Date	

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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:	_12	29	20
	Month	Day	Year
2. Name of medical practice or facility at v Planned Parenthood	vhich RU-486 was provi	ded:	
3. Address of medical practice or facility at	which RU-486 was prov	rided:	
2314 Auburn Aus.	ana, of	45219	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
10.	erse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe bleed	ling		
Other serious event (specify)			
. Duration of event: Hours	20 Days		
. Remarks:			
2 Name of the control of			
a. Name of physician who provided RU-486	5 00	Kalsy	
b. Physician's signature	Date 4/13	/21 (MD)/D	0
od complete d f	dical Decade (Ol :		

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