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: March (Month) 4 (Day) 2022 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Your Choice Healthcare LLC

MAR 28 2022
STATE MEDICAL BOARD OF OHIO

3. Address of medical practice or facility at which RU-486 was provided:
6721 Karl Rd Columbus OH 43229

4. Date post RU-486 complication began:
3-21-2022

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

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

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) ______

6. Duration of event: 1 Hours 0 Days

7. Remarks: Patient did not complete protocol after administration of mifepristone. Viable pregnancy noted at f/u, >10 wks. Referred for surgical abortion.

8. a. Name of physician who provided RU-486 William Roddick MD

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

Date 3-22-22

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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: Feb (Month) 28 (Day) 2022 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Your Choice Healthcare LLC

3. Address of medical practice or facility at which RU-486 was provided:
6721 Karl Rd, Columbus OH 43229

4. Date post RU-486 complication began:
3-7-22

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

x Failed ~~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 0 Days

7. Remarks: Continuing pregnancy at f/u. Repeated misoprostol/mifepristone.

8. a. Name of physician who provided RU-486 L. Ann Nunnally, MD

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

Date 3-4-22

Send completed forms to:

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

MAR 16 2022
STATE MEDICAL BOARD OF OHIO

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: Dec (Month) 21 (Day) 2021 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Your Choice Healthcare LLC

3. Address of medical practice or facility at which RU-486 was provided:
6721 Karl Rd, Columbus OH 43229.

4. Date post RU-486 complication began:
1.5.2022

5. Event(s) (Please check all that apply):
X Failed 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 0 Days

7. Remarks:
Failed mAB. medication repeated & success.

8. a. Name of physician who provided RU-486 William Noddings MD

8. b. Physician's signature _____ (M.D./D.O.)
Date 1.12.2022

Send completed forms to:

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

JAN 24 2022
STATE MEDICAL BOARD OF OHIO

State Medical Board of Ohio

Report of RU-486 Event

DEC 10 2021

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided: 9 (Month) 7 (Day) 2021 (Year)

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

Your Choice Healthcare, LLC

3. Address of medical practice or facility at which RU-486 was provided:

6721 Karl Rd Cols, Oh 43229

4. Date post RU-486 complication began: 9/22/2021

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 5 Days

7. Remarks: Reffered for SAB

8. a. Name of physician who provided RU-486 William Roddick

8. b. Physician's signature L.A. Nally MD (M.D./D.O.)

Date 11/16/2021

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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: June (Month) 14 (Day) 2021 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Your Choice Healthcare CCC

3. Address of medical practice or facility at which RU-486 was provided:
6721 Karl Road
Columbus OH 43229

4. Date post RU-486 complication began:
June 18, 2021

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

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

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours 0 Days

7. Remarks: Failed MAB. Patient electing to continue pregnancy.

8. a. Name of physician who provided RU-486 L. Ann Nunnally, MD

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

Date 6.18.21

Send completed forms to:

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

MEDICAL BOARD
JUN 23 2021

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:	June (Month)	8 (Day)	2021 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Your Choice Healthcare LLC

3. Address of medical practice or facility at which RU-486 was provided:
6721 Karl Rd. Columbus OH 43229

4. Date post RU-486 complication began:
6/30/21

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

✓ ~~Incomplete~~ failed abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) ______________________

6. Duration of event: 1 Hours 0 Days

7. Remarks: Failed MAB. Referred patient for surgical AB at another facility.

8. a. Name of physician who provided RU-486 L.A. Nwnaky MD

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

Date 6.30.21

Send completed forms to:

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

MEDICAL BOARD
JUL 07 2021