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: 01 (Month) 09 (Day) 2017 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 East Main St., Columbus, Ohio 43213

4. Date post RU-486 complication began: 1/23/17

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 10 Days

7. Remarks:
D+C after incomplete Medication Abortion

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 1/30/17

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

MEDICAL BOARD
FEB 01 2017

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: 01 (Month) 17 (Day) 2017 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 East Main St., Columbus, Ohio 43213

4. Date post RU-486 complication began: 01/24/17

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed Medication Abortion

6. Duration of event: _____ Hours 8 Days

7. Remarks: D+C after failed medication abortion

8. a. Name of physician who provided RU-486: Catherine Romanos

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

Date 1/30/17

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

MEDICAL BOARD
FEB 01 2017

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) 19 (Day) 2017 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 East Main St., Columbus, Ohio 43213

4. Date post RU-486 complication began: 1/30/17

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 11 Days

7. Remarks:
Incomplete MAB requiring D&C

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 2/21/17

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

MEDICAL BOARD
FEB 22 2017

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) 6 (Day) 2017 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 East Main St., Columbus, Ohio 43213

4. Date post RU-486 complication began: 2/14/17

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed Medication Abortion

6. Duration of event: _____ Hours 8 Days

7. Remarks: Failed Medication Abortion requiring surgical D+C

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

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

Date 2/21/17

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

STATE MEDICAL BOARD
FEB 22 2017

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) 23 (Day) 17 (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:
3255 East Main St Columbus OH

4. Date post RU-486 complication began:
3/2/17

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 1 Days

7. Remarks: Med AB incomplete MISO repeat dosing.

8. a. Name of physician who provided RU-486 R Comanos

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

Date 3/7/17

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

MEDICAL BOARD
MAR 17 2017

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

10

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: 03 (Month) 30 (Day) 2017 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3235 East main St, Columbus OH, 43213

4. Date post RU-486 complication began: 4/3/17

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:
D;C perfomed. uncomplicated.

8. a. Name of physician who provided RU-486 Catherine Romano DO

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

Date 4/4/17

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

MEDICAL BOARD
APR 07 2017

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: April 24 2017
   Month Day Year

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

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:
   5/1/17

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

   MEDICAL BOARD
   MAY 12 2017

   X Incomplete abortion
   ___ Adverse reaction to RU-486
   ___ Patient hospitalized
   ___ Patient received a transfusion
   ___ Severe bleeding
   ___ Other serious event (specify) _____

6. Duration of event: N/A Hours _____ Days

7. Remarks:
   Incomplete MAB, D&C performed 5/9/17

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

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

Date 5/9/17

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

MEDICAL BOARD
MAY 2 2017

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

13

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: June (Month) 1 (Day) 2017 (Year)

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

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: 6/9/17

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) Hematometra

6. Duration of event: _____ Hours _____ Days

7. Remarks: Patient had aspiration on 6/9/17

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 6/14/17

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

MEDICAL BOARD
JUN 19 2017

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

14

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: June (Month) 7 (Day) 2017 (Year)

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

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:
6/21/17 at MAB follow up

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

✓ failed ~~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:
Surgical AB after medical AB on 6/22/17

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 6/27/17

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

MEDICAL BOARD
JUN 28 2017

15

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: June ~~26~~ 13 2017
Month Day error (M) Year

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

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:
June 26, 2017

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:
6/26 - Surgical AB after incomplete Med AB

8. a. Name of physician who provided RU-486 Catherine Ramanos

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

Date ~~6/22/17~~ error 6/27/17

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

MEDICAL BOARD
JUN 28 2017

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

14

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) 23 (Day) 17 (Year)

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

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: 7/3/17

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) failed MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks: Suction on 7/3/17 at MAB Follow up appt

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 7/5/17

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

MEDICAL BOARD
JUL 10 2017

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

17

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: July (Month) 3 (Day) 2017 (Year)

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

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: 7/10/17

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 _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Catharine Romanos

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

Date 7/12/17

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

MEDICAL BOARD
JUL 13 2017

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

16

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) 16 (Day) 17 (Year)

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

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: 8/21/17

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks: Dilation and suction - uncomplicated.

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 8/22/17

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

MEDICAL BOARD
AUG 24 2017

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) 28 (Day) 17 (Year)

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

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: 9/7/17

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 _____ Days

7. Remarks:
uncomplicated suction procedure

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 9/21/17

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

MEDICAL BOARD
SEP 25 2017

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: 9 (Month) 18 (Day) 17 (Year)

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

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:
9/22/17

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) failed Medication abortion

6. Duration of event: _____ Hours _____ Days

7. Remarks:
uncomplicated suction

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 9/25/17

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 2017

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

24

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) 21 (Day) 17 (Year)

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

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: 9/25/17

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 _____ Days

7. Remarks: uncomplicated D&C

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 9/27/17

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 2017

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

25

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: Sept (Month) 25 (Day) 2017 (Year)

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

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:
10/3/17

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: Incomplete D&C

8. a. Name of physician who provided RU-486 Catherine Pomaros

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

Date 10/16/17

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

MEDICAL BOARD
OCT 23 2017

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: Oct. (Month) 9 (Day) 2017 (Year)

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

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:
10/13/17

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) failed MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 10/14/17

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

MEDICAL BOARD
OCT 18 2017

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

MEDICAL BOARD
NOV 03 2017

1. Date RU-486 was provided: 10 (Month) 11 (Day) 17 (Year)

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

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:
10/31/17

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 _____ Days

7. Remarks:
uncomplicated D&C

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 10/31/17

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: Oct (Month) 16 (Day) 2017 (Year)

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

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: 11/22/17

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 _____ Days

7. Remarks: uncomplicated D:C

8. a. Name of physician who provided RU-486 Catherine Romanos MD/DO

8. b. Physician's signature _____ Date 11/28/17

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

MEDICAL BOARD
NOV 30 2017

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: Oct (Month) 18 (Day) 2017 (Year)

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

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:
10/23/17

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 _____ Days

7. Remarks:
uncomplicated DC

8. a. Name of physician who provided RU-486 Catharine Romanos

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

Date 12/25/17

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

MEDICAL BOARD
OCT 30 2017

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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) 18 (Day) 17 (Year)

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

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:
10/25/17

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 _____ Days

7. Remarks:
uncomplicated D&C

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 11/2/17

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

MEDICAL BOARD
NOV 06 2017

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

31

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: Nov (Month) 9 (Day) 2017 (Year)

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

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: 11/17/17

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks:
uncomplicated Surgical

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 11/21/17

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

MEDICAL BOARD
NOV 24 2017

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

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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) 20 (Day) 17 (Year)

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

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: 11/30/17

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) failed MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks:
uncomplicated D:C

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 12/15/17

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

DEC 18 2017

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

MEDICAL BOARD

MAY 10 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: April (Month) 9 (Day) 2021 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 4-30-2021

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) _____

6. Duration of event: ___1___ Hours _____ Days

7. Remarks:
uncomplicated sucTx a

8. a. Name of physician who provided RU-486 Catherine Romanos

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

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

MAY 1 0 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) 9 (Day) 2021 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 4/19/2021

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) _____

6. Duration of event: ___ Hours ___ Days

7. Remarks:
uncomplicated suctra

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

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

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

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) 4 (Day) 2021 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 3/22/2021

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) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks:
Dilation & Suction

8. a. Name of physician who provided RU-486 Katherine Romanos

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

Date 3/25/21

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

MEDICAL BOARD
MAR 31 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:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 2/9/21

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: _____ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Catherine Romanos MD DO

8. b. Physician's signature _____

Date 2/11/21

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

MEDICAL BOARD
FEB 22 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) 8 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 2/16/21

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:

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 2/18/21

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

MEDICAL BOARD
MAR 01 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: April (Month) 29 (Day) 2021 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 5/3/2021

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 _____ Days

7. Remarks:
uncomplicated

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 5/6/2021

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

MEDICAL BOARD
MAY 24 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) 10 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 7/14/21

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: Suction (uncomplicated)

8. a. Name of physician who provided RU-486 Catherine Romanos

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

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 22 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: July (Month) 22 (Day) 2021 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: July 27, 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) Failed MAB

6. Duration of event: 1 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Catherine Romanos MD

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

Date 7/29/21

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: 7 (Month) 22 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 7/28/21

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: ___1___ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 7/29/21

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

MEDICAL BOARD

JUN 24 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) 11 (Day) 2021 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 6/16/2021

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) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks:
uncomplicated D:C

8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature _____ MD DO

Date 6/16/21

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

MEDICAL BOARD

JUN 24 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: 05 (Month) 28 (Day) 2021 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

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 _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 6/3/21

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

MEDICAL BOARD

JUN 24 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: 3 (Month) 12 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 6/3/21

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 _____ Days

7. Remarks:
D & E uncomplicated.

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 6/4/21

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

MEDICAL BOARD

JUN 24 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: 06 (Month) 04 (Day) 2021 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 6/9/21

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: ___/___ Hours _____ Days

7. Remarks:
D. E.

8. a. Name of physician who provided RU-486 Catherine Romanos

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

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: 7 (Month) 2 (Day) 2021 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 8-9-2021

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: 1 Hours _____ Days

7. Remarks:
D.C.

8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature _____ MD DO

Date 8/12/21

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

MEDICAL BOARD
AUG 19 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) 3 (Day) 2021 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 8-3-2021

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) _____

6. Duration of event: 4 Hours _____ Days

7. Remarks:
D:E

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 8/5/21

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

MEDICAL BOARD
AUG 19 2021

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

MEDICAL BOARD
AUG 31 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: July (Month) 9 (Day) 2021 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 8-19-2021

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) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks:
Dilation Suction.

8. a. Name of physician who provided RU-486 Catherine Romanos MD

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

Date 8/19/20

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 R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 9 (Month) 17 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 10/1/21

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: 1 Hours _____ Days

7. Remarks:
dilation : suction

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 10/1/21

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

MEDICAL BOARD
OCT 19 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: 11 (Month) 19 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 11/24/21

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed Abortion

6. Duration of event: _____ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature [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 15 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: 12 (Month) 23 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began:
1/6/22

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: 1 Hours _____ Days

7. Remarks:
uncomplicated suction.

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 1/6/22

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

FEB 11 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: December (Month) 3 (Day) 2021 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 12/16/21

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:
uncomplicated suction

8. a. Name of physician who provided RU-486 Catherine Romano

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

Date 12/16/21

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

FEB 11 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) 12 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 01/04/22

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: 1 Hours _____ Days

7. Remarks:
Uncomplicated Dilation: Suction

8. a. Name of physician who provided RU-486 Catherine Remaros

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

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

FEB 11 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: 2 (Month) 10 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 3/17/22

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: 1 Hours _____ Days

7. Remarks:
Suction

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 3/17/22

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

MAR 21 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: 01 (Month) 14 (Day) 2022 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 3/18/22

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: 1 Hours _____ Days

7. Remarks:
Suction

8. a. Name of physician who provided RU-486 Catherine Romanos, MD

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

Date 3/10/22

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

MAR 21 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: 3 (Month) 3 (Day) 2022 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

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

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: 1 Hours _____ Days

7. Remarks:
Suction

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

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

APR 06 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: 11/18/2014 (Month / Day / Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 East Main St. Columbus, OH 43213

4. Date post RU-486 complication began: 12/09/2014

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: NA Hours _____ Days

7. Remarks: failed medical Ab likely result of FDA protocol.

8. a. Name of physician who provided RU-486 Catherine Kamanos MD

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

Date 12/9/14

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

MEDICAL BOARD
DEC 11 2014

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: August (Month) 28, (Day) 2014 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 East Main Street
Columbus, OH 43213

4. Date post RU-486 complication began:
September 12, 2014

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: n/a Hours _____ Days

7. Remarks:
FDA protocol resulted in incomplete procedure

8. a. Name of physician who provided RU-486 Catherine Karanos M.D.

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

Date 9/16/2014

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

MEDICAL BOARD
SEP 19 2014

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: Jan (Month) 22 (Day) 2018 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus OH 43213

3255 E. Main St.
Columbus OH 43213

4. Date post RU-486 complication began: 1/26

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) failed MAB

6. Duration of event: 2 Hours 0 Days

7. Remarks: uncomplicated Dilation: Suction

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 2/7/18

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

MEDICAL BOARD
FEB 12 2018

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: January (Month) 29 (Day) 2018 (Year)

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

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: 3/21/18

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) failed MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks:
uncomplicated D-E

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 3/29/18

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

MEDICAL BOARD

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) 30 (Day) 18 (Year)

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

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: 2/8/18

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) failed MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Catherine Romanos

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

MEDICAL BOARD

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: Feb (Month) 19 (Day) 2018 (Year)

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

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: 2/28/18

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 _____ Days

7. Remarks:
uncomplicated suction

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 3/8/18

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

MEDICAL BOARD

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

4

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: March 22 2018
   Month Day Year

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

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: 4/5/18

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

___ Incomplete abortion
___ Adverse reaction to RU-486
___ Patient hospitalized
___ Patient received a transfusion
___ Severe bleeding
X Other serious event (specify) failed abortion

6. Duration of event: _____ Hours _____ Days

7. Remarks: complicated suction.

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 4/19/18

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

MEDICAL BOARD
APR 2018

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

8

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: April (Month) 19 (Day) 2018 (Year)

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

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:
4/24/18

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 _____ Days

7. Remarks:
Uncomplicated D&C

8. a. Name of physician who provided RU-486 Katherine Romanos

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

Date 5/2/18

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

MEDICAL BOARD
MAY [illegible] 2018

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) 14 (Day) 18 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began:

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) failed medication abortion

6. Duration of event: ___1___ Hours _____ Days

7. Remarks:
uncomplicated dilation and suction

8. a. Name of physician who provided RU-486 Catherine Remanus, MD

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

Date 1/10/19

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

MEDICAL BOARD
JAN 22 2019

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: 02 (Month) 04 (Day) 2020 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 2/18/2020

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: bleeding after MTB
uncomplicated suction

8. a. Name of physician who provided RU-486 Catherine Romanos, MD

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

Date 2/18/20

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

MEDICAL BOARD
FEB 27 2020

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) 2020 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date patient RU-486 complication began:

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: 24 Hours _____ Days

7. Remarks:
uncomplicated D:E

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 6/10/20

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 2020

Prescribed by OAC 4731-11, 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	24	2020
	Month	Day	Year

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 5/26/2020

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

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

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) failed MAB

6. Duration of event: 4 Hours ___ Days

7. Remarks:
uncomplicated D:E

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 5/27/20

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

MEDICAL BOARD
JUN 09 2020

Prescribed ... 11 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: 04 (Month) 29 (Day) 2020 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began:

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: 1 Hours _____ Days

7. Remarks:
Dilation and Suction

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 5/15/20

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

MEDICAL BOARD
MAY 27 2020

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) 30 (Day) 2020 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began:

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: _____ Hours _____ Days

7. Remarks:
dilation suction

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

8. b. Physician's signature _____ MD DO

Date 5/14/20

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

MEDICAL BOARD
MAY 18 2020

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) 8 (Day) 2020 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 9/2/2020

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) Failed MAB

6. Duration of event: 3 Hours _____ Days

7. Remarks:
D: E

8. a. Name of physician who provided RU-486 Catherine Romanos, MD

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

Date 9/3/20

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

MEDICAL BOARD
SEP 09 2020

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: 7 (Month) 24 (Day) 2020 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 10/12/20

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) failed m tb

6. Duration of event: 24 Hours _____ Days

7. Remarks:
uncomplicated D: E

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 10/15/20

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

MEDICAL BOARD
OCT 26 2020

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) 13 (Day) 2020 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 8-17-2020

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

___ Incomplete abortion (medical) ___ 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:
D & S - uncomplicated

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

8. b. Physician's signature _____ MD DO

Date 8/19/20

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

MEDICAL BOARD
AUG 24 2020

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) 9 (Day) 2020 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 10/16/20

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~~ Catherine Romanos

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

Date 10/22/20

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

MEDICAL BOARD
NOV 12 2020

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) 20 (Day) 20 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 11/24/20

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:
uncomplicated suction

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

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

Date 12/3/20

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

MEDICAL BOARD
DEC 09 2020

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

MEDICAL BOARD

JAN 27 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: 12 (Month) 11 (Day) 2020 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 01-12-2021

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) Continuing pregnancy

6. Duration of event: 1 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 1/14/21

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: 12 (Month) 17 (Day) 2020 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began:
12-19-20

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: 24 Hours _____ Days

7. Remarks:
uncomplicated suction

8. a. Name of physician who provided RU-486 Catherine Romanos MD

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

Date 12/23/20

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

MEDICAL BOARD
JAN 04 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) 23 (Day) 20 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 12/28/20

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:
uncomplicated suction

8. a. Name of physician who provided RU-486: Catherine Romeros

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

Date 1/10/21

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

MEDICAL BOARD
JAN 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: 08 (Month) 01 (Day) 19 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 8/13/19

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: 1 Hours _____ Days

7. Remarks:
uncomplicated dilation and suction

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 8/15/19

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

MEDICAL BOARD
AUG 26 2019

Prescribed 5/--/2013 Rev. 12/13/13

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: 07 (Month) 19 (Day) 19 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 08/05/19

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:
uncomplicated dilation and suction.

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 8/16/19

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

MEDICAL BOARD
AUG 26 2019

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: July (Month) 15 (Day) 2019 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 8/6/19

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:
uncomplicated suction.

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 8/16/19

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

MEDICAL BOARD
AUG 26 2019

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: May (Month) 03 (Day) 2019 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 5/17/19

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) retained clot

6. Duration of event: 1 Hours _____ Days

7. Remarks:
uncomplicated suction

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 5/20/19

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

MEDICAL BOARD
JUN 17 2019

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: April (Month) 11 (Day) 2019 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 5/14/19

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) Failed MAB

6. Duration of event: 1 Hours _____ Days

7. Remarks:
Uncomplicated Dilation and Suctra

8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature _____ MD100

Date 5/20/19

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

MEDICAL BOARD
JUN 17 2019

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: April (Month) 1 (Day) 2019 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 4/22/19

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:
dilation and suction

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 4/22/19

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

MEDICAL BOARD
APR 29 2019

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: March 18 2019
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 3/19/19

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:
tissue removed from cervical os
uncomplicated suction

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 4/16/19

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

MEDICAL BOARD
APR 25 2019

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: March (Month) 7 (Day) 2019 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 3/12/19

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: uncomplicated dilation suction

8. a. Name of physician who provided RU-486 Catherine Romanes

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

Date 3/21/19

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

MEDICAL BOARD
APR 01 2019

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

MEDICAL BOARD

APR 10 2019

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: February (Month) 28 (Day) 2019 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 4/5/19

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:
suction - uncomplicated.

8. a. Name of physician who provided RU-486 Catherine Romanos MD

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

Date 4/5/19

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: February (Month) 22 (Day) 2019 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 2/27/19

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: tissue remved 9mm OS. Suction uncomplicated.

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 4/16/19

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

MEDICAL BOARD
APR 25 2019

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: February (Month) 07 (Day), 2019 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 02/21/19

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 0 Days

7. Remarks:
uncomplicate dilation: suction.

8. a. Name of physician who provided RU-486 Catherine Romanos, MD

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

Date 2/21/19

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

MEDICAL BOARD
MAR 04 2019

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: January (Month) 25 (Day) 2019 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 1/31/2019

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) failed medication abortion

6. Duration of event: 1 Hours _____ Days

7. Remarks:
uncomplicated dilation and suction

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 1/31/19

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

MEDICAL BOARD
FEB 19 2019

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: January (Month) 21 (Day) 2019 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 2/14/19

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:
uncomplicated dilation and suction

8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature _____ MD DO

Date 2/14/19

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

MEDICAL BOARD
MAR 04 2019

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: January (Month) 11 (Day) 2019 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began:

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) failed medication abortion

6. Duration of event: 1 Hours _____ Days

7. Remarks:
uncomplicated D&C and Suction.

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 1/16/19

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: January (Month) 13 (Day), 2015 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 East Main St., Columbus, OH 43213

4. Date post RU-486 complication began: 1/30/15

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: N/A Hours _____ Days

7. Remarks:
failed secondary to FDA protocol

8. a. Name of physician who provided RU-486 Catherine Romans

8. b. Physician's signature _____ MD DO

Date 2/3/15

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

MEDICAL BOARD
FEB 9 2015

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: October 13, 2015 (Month / Day / Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 East Main St. Columbus, OH 43213

4. Date post RU-486 complication began:
10/29/2015

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: incomplek medication abortion following FDA approved. protocol.

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 10/28/15

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

MEDICAL BOARD
NOV 2 2015

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

2

State Medical Board of Ohio

Report of RU-486 Event

MEDICAL BOARD

MAR 8 2016

(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) 22 (Day) 16 (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: 3255 E Main St. Columbus OH 43213

4. Date post RU-486 complication began:

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: N/a Hours _____ Days

7. Remarks: failed MAB (non viable IUP) due to FDA regimen

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 3/3/16

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

43

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: April (Month) 11 (Day) 2016 (Year)

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

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: 4/25/16

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 _____ Days

7. Remarks: failed medication abortion, continuing pregnancy

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

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

Date 4/25/16

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

MEDICAL BOARD
APR 26 2016

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: April (Month) 21 (Day) 2016 (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: 3255 E. Main St. Columbus OH 43213

4. Date post RU-486 complication began: 4/22/16

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

X Incomplete abortion ERC 4/27/16 ___ 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: D:C for bleeding.

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 4/27/16

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

MEDICAL BOARD
MAY 2 2016

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: June (Month) 3 (Day) 2016 (Year)

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

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: 6/7/16

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) _____

MEDICAL BOARD
JUN 13 2016

6. Duration of event: 24 Hours _____ Days

7. Remarks: incomplete expulsion of POC due to severe fibroid uterus.

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 6/9/16

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: June (Month) 10 (Day) 2016 (Year)

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

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: 6/15/16

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: failed medication abortion s/p D&C

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

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

Date 6/15/16

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

MEDICAL BOARD
JUN 17 2016

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: July (Month) 05 (Day), 2016 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
355 East Main St. Columbus, OH 43213

4. Date post RU-486 complication began:
07/14/2016

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: Failed medical abortion completed surgically

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

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

Date 7/15/2016

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

MEDICAL BOARD
JUL 18 2016

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: August (Month) 16 (Day) 2016 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 W. Main St.
Columbus, OH 43213

MEDICAL BOARD
AUG 29 2016

4. Date post RU-486 complication began: 8/24/2016

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed medical abortion

6. Duration of event: 2 Hours _____ Days

7. Remarks:
Surgical completion of abortion

8. a. Name of physician who provided RU-486 C. Romanos

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

Date 8/24/2016

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

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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: September 27 2016
   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:
   3255 E. Main St Columbus OH 43213

4. Date post RU-486 complication began: 10/5/16

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) _____

MEDICAL BOARD
OCT 17 2016

6. Duration of event: _____ Hours _____ Days

7. Remarks:
   incomplete MAB required suction procedure

8. a. Name of physician who provided RU-486 ~~Lisa Kader~~ Catherine Romanos

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

Date 10/12/16

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: November (Month) 3 (Day) 2016 (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:
3255 East Main Street
Columbus, OHIO 43213

4. Date post RU-486 complication began: 11/10/16

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 19 Days

7. Remarks:

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 11/22/16

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

MEDICAL BOARD
NOV 25 2016

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

6

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: November (Month) 17 (Day) 2016 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 East Main St
Columbus, OH 43213

4. Date post RU-486 complication began:
12/15/16

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed Medication Abortion

6. Duration of event: _____ Hours 33 Days

7. Remarks:
D. C performed - uncomplicated.

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 12/29/16

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

MEDICAL BOARD
JAN 03 2017

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: November (Month) 22 (Day) 2016 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 East Main St
Columbus, Ohio 43213

4. Date post RU-486 complication began:
12/6/16

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed Abortion

6. Duration of event: _____ Hours ~~4~~ 21 Days

7. Remarks:
FDA mudication abortion @ 9w 3d failed. DiC for ongoing IUP on 12/13/16.

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 12/13/16

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

MEDICAL BOARD
DEC 16 2016

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

2

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) 29 (Day) 2016 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 East Main St., Columbus, Ohio 43213

4. Date post RU-486 complication began: 1/3/17

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed Medication Abortion

6. Duration of event: _____ Hours 45 Days

7. Remarks: Failed Medication Abortion with D&C procedure

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 1/17/17

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

MEDICAL BOARD
JAN 19 2017

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) 6 (Day) 2016 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 East Main St, Columbus, OH 43213

4. Date post RU-486 complication began: 1/5/17

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed Medication Abortion

6. Duration of event: _____ Hours 35 Days

7. Remarks: Failed Medication Abortion with D&C procedure

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 1/17/17

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

MEDICAL BOARD

JAN 19 2017

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) 13 (Day) 16 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 East Main St
Columbus, OH 43213

4. Date post RU-486 complication began:
12/21/16

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed Medication Abortion

6. Duration of event: _____ Hours 9 Days

7. Remarks:
D&C performed incomplete

8. a. Name of physician who provided RU-486 Catherine Romanas

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

Date 12/29/16

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

MEDICAL BOARD
JAN 03 2017

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: December (Month) 15 (Day) 2016 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
3255 East Main St., Columbus, OHIO 43213

4. Date post RU-486 complication began: 12/22/16

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

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

___ Patient received a transfusion ___ Severe bleeding

MEDICAL BOARD
JAN 10 2017

X Other serious event (specify) Failed Medication Abortion

6. Duration of event: _____ Hours 15 Days

7. Remarks:
failed medication abortion resolved with D:C - uncomplicated

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 1/9/2017

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