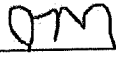


# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>January</u> Month	<u>02</u> Day	<u>2024</u> Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):  <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized  <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding  <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed abortion (ongoing pregnancy)</u>			
6. Duration of event: <u>1</u> Hours <u>      </u> Days			
7. Remarks: MAB procedure initiated per FDA regimen on 11/03/2023. Follow up US on 01/02/24 revealed continuing pregnancy.			
8. a. Name of physician who provided RU-486 <u>Jackie Mostow MD</u>			
8. b. Physician's signature <u></u> <u>MD/DO</u>			
Date <u>4/24/24</u>			

Send completed forms to: State Medical Board of Ohio  
Legal Department  
30 E. Broad St., 3<sup>rd</sup> Floor  
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MAY 06 2024  
STATE MEDICAL BOARD OF OHIO



# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

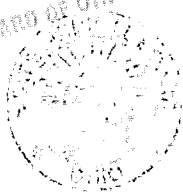
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	2/13/24
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio	
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146	
4. Date post RU-486 complication began:	4/18/24
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____	
6. Duration of event: <u>1</u> Hours <u>      </u> Days	
7. Remarks: Patient provided Mifepristone for MAB per FDA regimen on 2/13/24. Patient seen 4/18/24 for MAB F/U for continued bleeding post-MAB. Non-viable intrauterine pregnancy found on ultrasound. Patient referred to ED for further treatment due to severe anemia.	
8. a. Name of physician who provided RU-486 <u>Ashley Brant</u>	
8. b. Physician's signature <u><i>Ashley Brant</i></u> <u>      </u> M.D./D.O. Date <u>      </u>	

Send completed forms to: State Medical Board of Ohio  
Legal Department  
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MAY 06 2024  
STATE MEDICAL BOARD OF OHIO

MAR 19 2024  
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:	02	15	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: 3/2/24			
5. Event(s) (Please check all that apply):  <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized  <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding  <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed Abortion</u>			
6. Duration of event: <u>1</u> Hours <u>      </u> Days			
7. Remarks: MAB procedure initiated per FHD regimen on 2/15/24. Follow up ultrasound preformed on 3/2/24 revealed continuing pregnancy. Pt opted for second dose of MAB medications.			
8. a. Name of physician who provided RU-486 <u>Bhavik Kumar</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>3/13/2024</u>			

Send completed forms to:

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Legal Department  
30 E. Broad St., 3<sup>rd</sup> 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:	2	17	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: 2/23/24			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 1 Hours _____ Days			
7. Remarks: MAB Initiated per FDA regimen on 2/17/24. Pt called into emergency line 2/23/24 with c/o passing large clots, lightheadedness, 10/10 pain, and soaking 1 pad an hour. Pt advised to be seen in ED for urgent evaluation. 2/23/24 pt had D&C, received 2 units of blood, and discharged same day.			
8. a. Name of physician who provided RU-486: Zaidan Vickery			
8. b. Physician's signature:  M.D./D.O.			
Date: 4/8/2024			

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Columbus, OH 43215-6127

Prescribed: 5/-/2011, Rev. 12/18/12

APR 15 2024

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:	February	26	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: April 8, 2024			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) Failed abortion.			
6. Duration of event: 1 Hours _____ Days			
7. Remarks: Medication abortion initiated per FDA regimen on 2/26/2024. Follow-up ultrasound revealed failed abortion on 4/8/2024. Surgical procedure scheduled for 4/15/2024. Patient did well post operation.			
8. a. Name of physician who provided RU-486 Dr. Freeman			
8. b. Physician's signature _____ M.D. / D.O. _____			
Date 4/15/24			

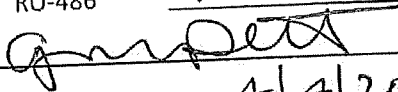
Send completed forms to: State Medical Board of Ohio  
Legal Department  
30 E. Broad St., 3<sup>rd</sup> Floor  
Columbus, OH 43215-6127



# 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:	3/7/24
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	Planned Parenthood of Greater Ohio
3. Address of medical practice or facility at which RU-486 was provided:	25350 Rockside Road, Bedford Heights, Ohio, 44146
4. Date post RU-486 complication began:	3/11/24
5. Event(s) (Please check all that apply):	<input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>FAILED MAB</u>
6. Duration of event:	<u>1</u> Hours <u>      </u> Days
7. Remarks:	Mifeprex administered per FDA regimen on 3/7/24. Patient took misoprostol on 3/8. Patient called to report little to no bleeding after misoprostol on 3/9. Patient had MAB follow-up US on 3/11 that showed continued pregnancy. Patient had D&C Suction 3/11. Did well post-op
8. a. Name of physician who provided RU-486	Amy Potter
8. b. Physician's signature	 M.D./D.O.
	Date <u>4/4/2024</u>

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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:	3	11	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began:	4/4/2024		
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 1 Hours _____ Days			
7. Remarks: Original MAB AB2 on 3/11/2024 with E Freeman DO. Patient returned to clinic on 4/4/2024 for suction procedure for retained POC. Suction procedure performed by A Potter, MD.			
8. a. Name of physician who provided RU-486 Emily Freeman, DO			
8. b. Physician's signature _____ M.D./D.O.			
Date 4/6/24.			

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Columbus, OH 43215-6127

APR 15 2024

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:	4	24	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: 6/4/24			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized: <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours _____ Days			
7. Remarks: MAB initiated per FDA regimen on 4/24/24. Follow up ultrasound on 6/4/24 revealed RPOC vs hematometra vs normal post-MAB findings. Pt is asymptomatic but is anxious about possibility of small RPOC. Pt opted for second dose of misoprostol.			
8. a. Name of physician who provided RU-486      Jackie Mostow			
8. b. Physician's signature <i>Jackie Mostow</i> M.D./D.O.			
Date      8/2/2024			

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Legal Department  
30 E. Broad St., 3<sup>rd</sup> Floor  
Columbus, OH 43215-6127

AUG 16 2024

STATE MEDICAL BOARD OF OHIO



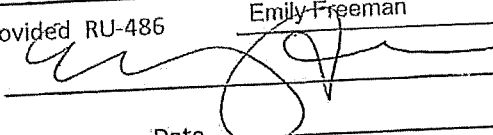
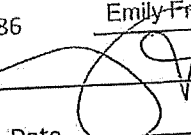


# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

JUN 17 2024  
STATE MEDICAL BOARD OF OHIO

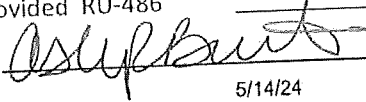
1. Date RU-486 was provided:	4	29	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: 6/6/24			
5. Event(s) (Please check all that apply):  <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized  <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding  <input checked="" type="checkbox"/> Other serious event (specify)      hematometra			
6. Duration of event:      1      Hours      Days			
7. Remarks: MAB initiated per FDA regimen on 4/29/24. Follow up ultrasound on 6/6/24 revealed hematometra. Pt opted for second dose of misoprostol			
8. a. Name of physician who provided RU-486      Emily Freeman			
8. b. Physician's signature  M.D./D.O.			
Date 			

Send completed forms to:      State Medical Board of Ohio  
Legal Department  
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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:	4/30/24
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio	
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146	
4. Date post RU-486 complication began:	5/11/24
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) failed MAB	
6. Duration of event: 1 Hours Days	
7. Remarks: MAB initiated per FDA regimen on 4/30/24. Patient experienced light bleeding. On 5/11/24 Follow-up Ultrasound showed continued pregnancy & Suction procedure performed same day. Patient did well post op.	
8. a. Name of physician who provided RU-486	Ashley Brant
8. b. Physician's signature	 M.D. / (D.O.)
Date	5/14/24

Send completed forms to:

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Legal Department  
30 E. Broad St., 3<sup>rd</sup> Floor  
Columbus, OH 43215-6127

MAY 17 2024  
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

JUN 17 2024  
STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided:	05	03	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: 5/03/24			
5. Event(s) (Please check all that apply):  <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized  <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding  <input checked="" type="checkbox"/> Other serious event (specify) <u>retained POC</u>			
6. Duration of event: <u>1</u> Hours <u>      </u> Days			
7. Remarks: Patient had appointment for medication abortion on 05/03/2024. Follow-up appointment with ultrasound on 5/13/2024. Retained POC found on ultrasound. Patient opted suction procedure after being counseled on options by physician. Procedure uncomplicated.			
8. a. Name of physician who provided RU-486 <u>Amy Potter MD</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u> Date <u>6/16/2024</u>			

Send completed forms to:

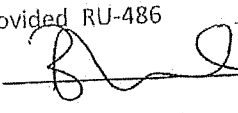
State Medical Board of Ohio  
Legal Department  
30 E. Broad St., 3<sup>rd</sup> Floor  
Columbus, OH 43215-6127



# 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:	5	16	24
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: 7/1/24			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 1 Hours _____ Days			
7. Remarks: MAB initiated per FDA regimen on 5/16/24. Follow up ultrasound on 7/1/24 revealed possible retained POC. Pt opted for suction procedure for 7/1/24			
8. a. Name of physician who provided RU-486      Bhavik Kumar			
8. b. Physician's signature  M.D./D.O.			
Date      7/19/24			

Send completed forms to:

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

AUG 07 2024

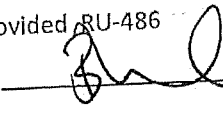
STATE MEDICAL BOARD OF OHIO



# 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:	05	17	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: 6/26/2024			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) hematometra			
6. Duration of event: 1 Hours Days			
7. Remarks: MAB 5/17/24 w/ B Kumar, MD. Pt RTC 6/26/2024 for follow-up visit due to moderate pelvic pain/cramping. Ultrasound performed. Re-suctioned performed at follow-up visit by B Kumar, MD.			
8. a. Name of physician who provided RU-486 Bhavik Kumar, MD			
8. b. Physician's signature  M.D./D.O.			
Date 6/26/24			

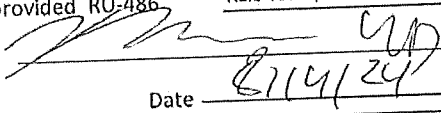
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Columbus, OH 43215-6127

JUL 08 2024  
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:	05/22/2024
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio	
3. Address of medical practice or facility at which RU-486 was provided: 26350 Rockside Road, Bedford Heights, Ohio, 44146	
4. Date post RU-486 complication began: 7/18/2024	
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) Failed Abortion	
6. Duration of event: 1 Hours Days	
7. Remarks: MAB 5/22/2024. RTC 7/18/2024 for follow-up. Suction procedure performed 7/18/2024 for failed abortion.	
8. a. Name of physician who provided RU-486 Kale Tuner, MD	
8. b. Physician's signature  M.D./D.O.	
Date 8/14/24	

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Columbus, OH 43215-6127

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

OCT 22 2024  
STATE MEDICAL BOARD OF OHIO



# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	6/10/2024
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio	
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146	
4. Date post RU-486 complication began: 7/18/2024	
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____	
6. Duration of event: 1 Hours _____ Days	
7. Remarks: MAB 6/10/2024. Pt RTC 7/18/2024 for follow-up. Incomplete AB determined. Pt RTC 7/19/2024 for suction procedure.	
8. a. Name of physician who provided RU-486 Emily Freeman, DO	
8. b. Physician's signature _____ M.D. / D.O.	
Date 7/22/24	

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State Medical Board of Ohio  
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30 E. Broad St., 3<sup>rd</sup> 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:	6	11	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: 6/25/24			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 1 Hours _____ Days			
7. Remarks: MAB initiated 6/11/24 per FDA regimen. Follow up ultrasound 6/25/24 noted an incomplete abortion. Pt opted for suction procedure 6/25/24.			
8. a. Name of physician who provided RU-486 Ashley Brant			
8. b. Physician's signature <u>Ashley Brant</u> M.D. / D.O. _____			
Date <u>6/25/24</u>			

Send completed forms to:

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

JUL 08 2024



# 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	16	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: 7/22/24			
5. Event(s) (Please check all that apply):  <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized  <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding  <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed abortion</u>			
6. Duration of event: <u>1</u> Hours <u>      </u> Days			
7. Remarks: MAB initiated per FDA regimen on 7/16/24. Ultrasound at follow up appt 7/22/24 revealed a failed medication abortion. Pt opted for suction procedure 7/22/24.			
8. a. Name of physician who provided RU-486 <u>Ashley Brant</u>			
8. b. Physician's signature <u><i>Ashley Brant</i></u> <u>      </u> M.D. / D.O.			
Date <u>7/23/24</u>			

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Legal Department  
30 E. Broad St., 3<sup>rd</sup> Floor  
Columbus, OH 43215-6127

AUG 07 2024  
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:	7	25	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: 9/17/23			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 1 Hours _____ Days			
7. Remarks: Pt presented for initial MAB on 7/25/2024. Pt RTC on 9/17/2024 for follow-up appt. Retained products determined. Suction procedure performed 9/17/2024 without complications.			
8. a. Name of physician who provided RU-486 Catherine Harmer, DO			
8. b. Physician's signature <u>C. Harmer</u> <u>M.D./D.O.</u>			
Date <u>4/8/24</u>			

Send completed forms to: State Medical Board of Ohio  
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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:	<u>7</u>	<u>26</u>	<u>2024</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: 9/12/2024			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>1</u> Hours <u>      </u> Days			
7. Remarks: Pt presented for initial MAB on 07/26/2024 at 7w2d. RTC 9/12/2024 for follow up. Ultrasound completed and showed retained products. Suction procedure completed 09/12/24 with no complications.			
8. a. Name of physician who provided RU-486 <u>Catherine Harmer, MD</u>			
8. b. Physician's signature <u></u> <u>MD / D.O.</u>			
Date <u>9/12/2024</u>			

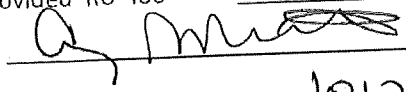
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SEP 20 2024  
STATE MEDICAL BOARD OF OHIO

# 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:	July	31	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: 9/10/2024			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 6 Hours _____ Days			
7. Remarks: Pt presented for initial MAB on 07/31/2024 at 8w4d. Came in on 09/10/2024 for follow up due to positive pregnancy test. Ultrasound completed and showed continuing pregnancy. Suction procedure completed 09/10/2024 with no complications.			
8. a. Name of physician who provided RU-486 Amy Burkett, MD			
8. b. Physician's signature  M.D./D.O.			
Date 10/2/24			

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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:	August	5	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: 10/30/24			
5. Event(s) (Please check all that apply):  <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized  <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding  <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed abortion</u>			
6. Duration of event: <u>1</u> Hours <u>      </u> Days			
7. Remarks: MAB 8/05/2024. Pt RTC 10/30/2024 for follow-up. Failed MAB determined via u/s showing a continuing pregnancy of 20w 2d EGD. Referred out to another clinic to receive care.			
8. a. Name of physician who provided RU-486 <u>Emily Freeman, DO</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. <u>      </u>			
Date <u>11/4/24</u>			

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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:	8	22	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: 9/17/2024			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 1 Hours _____ Days			
7. Remarks: Pt presented to clinic for MAB on 8/22/2024. Pt RTC 9/17/2024 for follow-up appt. Retained products noted on u/s. Pt RTC 9/19/2024 for suction procedure w/o complication.			
8. a. Name of physician who provided RU-486 Amy Potter			
8. b. Physician's signature _____ Date 9/20/2024			

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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:	August	28	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: 10/28/24			
5. Event(s) (Please check all that apply):  <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized  <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding  <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed Abortion</u>			
6. Duration of event: <u>1</u> Hours <u>      </u> Days			
7. Remarks: MAB performed on 8/27/2024. Pt RTC 10/28/2024 for follow-up. Failed MAB determined via u/s. Pt received PAB on 10/28/24 for continuing pregnancy.			
8. a. Name of physician who provided RU-486 <u>Ashley Brant, DO</u>			
8. b. Physician's signature <u><i>Ashley Brant</i></u> M.D. / D.O. <u>      </u>			
Date <u>10/29/24</u>			

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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

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1. Date RU-486 was provided:	9	10	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: 10/17			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 1 Hours _____ Days			
7. Remarks: Pt had MAB on 9/10/2024. RTC 10/17/2024 for follow-up. Incomplete MAB determined. Pt given miso. Pt RTC 10/25/2024 for follow-up. Incomplete AB determined. Suction procedure performed per Chen MD.			
8. a. Name of physician who provided RU-486 Ashley Brant, DO			
8. b. Physician's signature _____ M.D. / D.O. _____			
Date 10/29/24			

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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:	<u>9</u>	<u>10</u>	<u>2024</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: <u>9/10/2024</u>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>1</u> Hours _____ Days			
7. Remarks: MAB 9/10/2024. Pt RTC 10/17/2024 for follow-up. Incomplete MAB determined via u/s. Pt send home with additional dose of misoprostol.			
8. a. Name of physician who provided RU-486      Ashley Brant, DO			
8. b. Physician's signature <u>Ashley Brant</u> M.D. / D.O.			
Date <u>10/22/24</u>			

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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	12	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: 10/30/24			
5. Event(s) (Please check all that apply):  <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized  <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding  <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed abortion</u>			
6. Duration of event: <u>1</u> Hours <u>      </u> Days			
7. Remarks: MAB 9/12/2024. Pt RTC 10/30/2024 for follow-up. Failed MAB determined via u/s showing a continuing pregnancy of 16w 1d EGD. Received PAB.			
8. a. Name of physician who provided RU-486 <u>Catherine Harmer, MD</u>			
8. b. Physician's signature <u><i>C. Harmer</i></u> <u>      </u> M.D. / D.O. Date <u>11/8/24</u>			

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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	29	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: Pt visited ED 11/04/2024			
5. Event(s) (Please check all that apply):  <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized  <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding  <input checked="" type="checkbox"/> Other serious event (specify) Failed AB			
6. Duration of event: 1 Hours _____ Days			
7. Remarks: PUL MAB 10/29/2024. HCG quant levels continued to rise. Pt went to ED for c/o ectopic on 11/04/2024. Pt treated in ED w/ methotrexate for presumed ectopic pregnancy. No further follow-up visible in shared EMR. Upcoming D&C scheduled with outside provider for failed MAB.			
8. a. Name of physician who provided RU-486 A Brant DO			
8. b. Physician's signature <u><i>A Brant DO</i></u> M.D./D.O.			
Date <u>11/19/24</u>			

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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	12	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: 7/26/23			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized  <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding  <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: 1 Hours _____ Days			
7. Remarks: MAB on 11/12/24. PI RTC 11/19/24. U/S performed. RPOC visualized per physician. Pt counseled on procedural and medical options. Pt decided to take additional medication and sent home with misoprostol.			
8. a. Name of physician who provided RU-486 Ashley Brant, DO			
8. b. Physician's signature <u>Ashley Brant</u> M.D. / D.O.			
Date 11/26/24			

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