

APR 0 2 2020 STATE MEDICAL BOARD OF OWN.

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	J	/ 0	24
	Month	Day	Year
2. Name of medical practice or facility Planned Parenthood		led:	
3. Address of medical practice or facility	y at which RU-486 was prov	ided:	
2314 Auburn Aug	ana, of	45219	
4. Date post RU-486 complication began	n:		
5. Event(s) (Please check all that apply):			
∠ Incomplete abortion	_Adverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe	bleeding		
Other serious event (specify)			·
6. Duration of event: 2 Hours	Days		The second se
7. Remarks:			
C.			
B. a. Name of physician who provided RI	J-486 <u>De</u>	Kalsin	
3. b. Physician's signature	Male		0
	Date 1/2		
end completed forms to: State	Medical Board of Ohio	The state of the s	
Legal Depar	tment		
30 E. Broad	St., 3 <sup>rd</sup> Floor		
Columbus, C	DH 43215-6127		



#### APR UZ ZUZY State Medical Board of Ohio Report of RU-486 Event Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	2	.22	24
	Month	Day	Year
2. Name of medical practice or facility at when Planned Parenthood	ich RU-486 was pro	ovided:	
3. Address of medical practice or facility at w	hich RU-486 was p	rovided:	
2314 Auburn Aus. (	ana, of	45219	
4. Date post RU-486 complication began: $2/28/24$			
5. Event(s) (Please check all that apply):		4	
✓ Incomplete abortion Adve	erse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Severe bleed	ng		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:			
8. a. Name of physician who provided RU-48	6	Dr. Limi	
8. b. Physician's signature	)/	M.D./	'D.O.
	Date3/5	124	
Send completed forms to: State Me	edical Board of Ohio	3	

30 E. Broad St., 3<sup>rd</sup> Floor



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1 Data PIL 106 was and	idad.			
1. Date RU-486 was provi	dea:	_2	25	24
		Month	Day	Year
2. Name of medical pract	ice or facility at which	RIJ-486 was pro	vided:	
Planned Pl	mont hood	Southn	rest Ohio	)
3. Address of medical prac	tice or facility at which	n RU-486 was pri	ovided:	
2314 Aut	ur AM.	Ghc.	off 4	5219
4. Date post RU-486 comp		·		-
5. Event(s) (Please check a	II that apply):			***************************************
✓ Incomplete abortion	Adverse i	reaction to RU-486	Patient hospitalized	ì
Patient received a transfusion	on Severe bleeding			
Other serious event (specify	·)			
6. Duration of event:	Z Hours	_ Days		
7. Remarks:				
8. a. Name of physician who	provided RU-486	9	Dr. Gin-	
8. b. Physician's signature		2.1	M.D./1	2.0
	Date	- 4	1/25/24	
Send completed forms to:	State Medica	l Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 <sup>rd</sup> Fl	oor	á j	IAV Of mas
	Columbus, OH 4321	5-6127		IAY 0 6 2024
			STATE ME	DICAL BOARD OF ONIO



(Required pursuant to R.C. 2919,123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	_ 3	14	24
	Month	Day	Year
2. Name of medical practice or facil	. A	vided:	
3. Address of medical practice or fac	ility at which RU-486 was pro	ovided:	
2314 Auburn Au	4. ana, of	45219	
4. Date post RU-486 complication be $3/24/24$			
5. Event(s) (Please check all that app			
Incomplete abortion	Adverse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Seve	ere bleeding		
Other serious event (specify)			
5. Duration of event:2_Hou	ırs Days		
7. Remarks:			
. a. Name of physician who provided	RU-486	br sch an	N
. b. Physician's signature	Maly	-/24 MD/	D.O
end completed forms to: S	tate Medical Board of Ohio		
Legal De	partment		
30 E. Bro	oad St., 3 <sup>rd</sup> Floor		MAY 0.6 2024
Columbi	is OH 43215-6127		FINAL TO SE SUS. I

STATE MEDICAL BOARD OF OHIO

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



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	Vì	И	24
	Month	Day	Year
2. Name of medical practice or facility at which Planned Parent hood	<del>-</del>	ed:	
3. Address of medical practice or facility at which 2314 AUBURN Public .			45219
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Incomplete abortion Adverse	e reaction to RU-486 _	Patient hospita	alized
Patient received a transfusion Severe bleeding			
Other serious event (specify)		***************************************	
6. Duration of event: Hours	Days		
7. Remarks:	Walled to the second se		
8. a. Name of physician who provided RU-486	Dr. fen	sale	
8. b. Physician's signature  Da	1119	M	d/00
Send completed forms to: State Medi	ical Board of Ohio		
Legal Department			
30 E. Broad St., 3 <sup>rd</sup>	Floor		,

Columbus, OH 43215-6127

DEC 1 1 2024

STATE MEDICAL BOARD OF OHIO



SEP 0 y 2024 STATE MEDICAL BOARD OF OHIO

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	5	14	24	
	Month	Day	Year	
2. Name of medical practice or facility  Manual Parenthon	y at which RU-486 was provid Louth MJ+	led: Ohio Re	fion	
3. Address of medical practice or facil	ity at which RU-486 was prov	ided:		
2314 Auburn 1	Ave.			
4. Date post RU-486 complication begins $\log \sqrt{5/24}$	gan:			
5. Event(s) (Please check all that apple	/):			
Lincomplete abortion	Adverse reaction to RU-486	Patient hospitalize	d	
Patient received a transfusion Seve	re bleeding			
Other serious event (specify)				
			****	
6. Duration of event: Hou	rs Days			
7. Remarks:				
7. hemaiks.	~-			-
2 - Al		Keller		
3. a. Name of physician who provided	RU-486 <u>WC</u>	Kalsy		
3. b. Physician's signature	Date 1/2/	24 24	<u>'D.O</u>	
Send completed forms to:	tate Medical Board of Ohio			
Legal De	partment			

30 E. Broad St., 3<sup>rd</sup> Floor





(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	S	15	24
	Month	Day	Year
2. Name of medical practice or facility at v			
Planned Parenthood	Southwest	ohio	
3. Address of medical practice or facility at	which RU-486 was p	rovided:	
2314 Auburn +	42		
4. Date post RU-486 complication began:  H2/24			
5. Event(s) (Please check all that apply):			<u> </u>
Ancomplete abortionAc	iverse reaction to RU-486	S Patient hospitalize	d
Patient received a transfusion Severe blea	eding	,	
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:			
-	·· ·· Ville	E.	t <del>a</del>
8. a. Name of physician who provided RU-	486 <i>Dr</i>	c. Kalsy	
8. b. Physician's signature	Mala Date Ma	124 MB	<b>LD.O</b>
Send completed forms to: State I	Medical Board of Ohi	0	
Legal Departn	nent		

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



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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	_ (e		7	24
2. Name of medical arrati	Mor		Day	Year
2. Name of medical practice or faci	lity at which RU-486	was provide	ed:	
Planned Parenthe	od dout	West	Ohio	
3. Address of medical practice or fac	ility at which DU 400			
22 14 /	A	was provid	led:	
2314 Aubum	GVY.			
4. Date post RU-486 complication be	gan:			
4/18/24	Paris			
5. Event(s) (Please check all that app	lv)-	<b></b>		
	·1)*			
Incomplete abortion	Adverse reaction to	RU-486	Patient hospitalized	
Davione		-	Daganard	
Patient received a transfusion Seve	re bleeding			
•				
Other serious event (specify)				
Duration of event: 2 Hou	rs Dave			
		<u> </u>		
. Remarks:				
	in him here his			***
a Namo of physics				
a. Name of physician who provided	RU-486	1)	8 in sole	
b. Physician's signature	12/_			
	Date	8/30/2	4	
nd completed forms to:				
	te Medical Board of	Ohio		
Legal Depa				
30 E. Broad	i St., 3 <sup>rd</sup> Floor			

Columbus, OH 43215-6127

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



STO O O 2024

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

12 Name of 16		Month	Day	Year Year
2. Name of medica	al practice or facility at v	vhich RU-486 was pro	vided:	
Manned	Parent ho.	1 Couts	wit of	
3 Address of		4 00011191	THE ONIC	)
	cal practice or facility at	which RU-486 was pro	ovided:	
2314	Auburn  5 complication began:	Aur. Ghe	off 4	5241
4. Date post RU-486	o complication began:			
<u> </u>	24	7	-	
5. Event(s) (Please cl	heck all that apply).			
/				
Oincomplete abortion	Adv	erse reaction to RU-486	Dark	
			Panent hospitalized	d .
Patient received a tra	ansfusionSevere bleed	ing		
•				
Other serious event (:	specify)			
<b>D</b>	2			
Hittotion of access	Hours	Days		
. Duration of event:				
. Duration of event: . Remarks:				
				was an again
				was an ingirity
. Remarks:				and the state of t
. Remarks:	who provided RU-486		c. Kalsy	
. Remarks:	who provided RU-486	Malm	or. Kaby	
. Remarks:	n who provided RU-486 are	Malry	7/2/24	0

Legal Department

30 E. Broad St., 3<sup>rd</sup> Floor



State Medical Board of Ohio Management Board of Color 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	10	
	Month	Day	- 24
2. Name of medical practice or facility Planed Parath	at which RU-486 was provid	ed:	Year
<ol><li>Address of medical practice or facilit</li></ol>	y at which RU-486 was provide	ded:	
2314 Anbon	Ane. Cinci	. OH 45	241
4. Date post RU-486 complication began $7/23/24$	n:	/	
5. Event(s) (Please check all that apply):			
C	_ Adverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe l	bleeding		
Other serious event (specify)			
Duration of event: Hours	Dáys		
. Remarks:			
a. Name of physician who provided RU	-486 <u> </u>	buscher	
b. Physician's signature W	Wila	N.D/D.C	
nd completed forms to: State	Medical Board of Ohio	I VV VC	
Legal Departs		,	
30 E. Broad S	t., 3 <sup>rd</sup> Floor		
	1 43215-6127		



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:			
67/24/24	Month	Day	Year
2. Name of medical practice or facility at which RL $\rho > 0$	J-486 was provid	ded:	
3. Address of medical practice or facility at which F	U-486 was prov	ided:	
2314 Auburn Ave (in			
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Incomplete abortion Adverse rea	ction to RU-486	Patient hospitalized	
Patient received a transfusion Severe bleeding			
Other serious event (specify)			_
6. Duration of event: Hours	Days		
7. Remarks:		No. of the last of	
8. a. Name of physician who provided RU-486	Pr. 901	Sahaney M.D./D.O.	
8. b. Physician's signature Date –	(1)	MD/DO	
Send completed forms to: State Medical E	Board of Ohio	<b>f</b>	

Legal Department

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127

SEP 2 4 2024

STATE MEDICAL BOARD OF OMPO





(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	07	27	2024
	Month	Day	Year
2. Name of medical practice or facility at which Planned Parent hood	n RU-486 was prov	vided:	
3. Address of medical practice or facility at which	ch RU-486 was pro		
2314 Auburn Ave.	Cincinn	nti OH	45219
4. Date post RU-486 complication began: 69 127 1274			
5. Event(s) (Please check all that apply):			
Incomplete abortionAdverse	e reaction to RU-486	Patient hospita	alized
Patient received a transfusion Severe bleeding			
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:			
3. a. Name of physician who provided RU-486	1. Dr. Ku	by	
3. b. Physician's signature	Msky te 8/27/8	) y	)/0.0
	ical Board of Ohlo		***************************************
Legal Department 30 E. Broad St., 3 <sup>rd</sup>			



# State Medical Board of Ohio STATE MARCHAL SOCIAL SO

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<b>୦</b> ତ	01	2024
FB-	Month	Day	Year
2. Name of medical practice or facility a Planned Parent	t which RU-486 was provid	ed:	
3. Address of medical practice or facility	at which RU-486 was provi	đed:	F
2314 Auburn A	ve Cincinna	t' 0H	45219
4. Date post RU-486 complication began	:		
5. Event(s) (Please check all that apply):			
X'Incomplete abortion	Adverse reaction to RU-486	X Patient hospita	ilized
Patient received a transfusion Severe b	oleeding		
Other serious event (specify)			
6. Duration of event: Hours			
7. Remarks:			77,5~
8. a. Name of physician who provided R	U-486 VV. Lin	v	
8. b. Physician's signature	Date	May D	)/00
Send completed forms to: Stat	e Medical Board of Ohlo		
Legal Depar	rtment		
30 E. Broad	St., 3 <sup>rd</sup> Floor		



NOV 0.5 2024 NEW WASHING HOURS OF OURS

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	9	Le	24
	Month	Day	Year
2. Name of medical practice or facility at which Planned Parent No.	ch RU-486 was provi	ded:	
3, Address of medical practice or facility at wl			45219
4. Date post RU-486 complication began:	914124		
5. Event(s) (Please check all that apply):			-
Adve	rse reaction to RU-486	Patient hospita	alized
Patient received a transfusion Severe bleedi	ńg		
Other serious event (specify)			
6. Duration of event: 2 Hours	Ďays		
7, Remarks:			00-94 <u>0-0-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1</u>
8. a. Name of physician who provided RU-48	se Dr. Yal	50/	
8. b. Physician's signature		M	0/00
	Date		
Send completed forms to: State M	edical Board of Ohio		
Legal Departme			
30 E. Broad St.,	3 <sup>rd</sup> Floor		

MOV 05 2024



### State Medical Board of Ohio STATE MEMORY DE LONG COMP 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	7	24
	Month	Day	Year
2. Name of medical practice or facility at v Planned Parent V		ded:	
3. Address of medical practice or facility at	which RU-486 was prov	/ided:	
2314 Auburn Av			45219
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Incomplete abortionA	dverse reaction to RU-486	Patient hospit	alized
Patient received a transfusion Severe ble	eding		
Other serious event (specify)	mm, words and with AMPA. A firm to map to construct the contract of the contra	garagos anno ang garago anno ang garago anno ang garago anno ang garago anno anno ang garago anno anno ang garago anno anno anno anno anno anno anno a	de alternativation de sangage gap
6. Duration of event: Hours	Days		
7. Remarks:			
8.a. Name of physician who provided RU-	486 Dr. Per	vl-	
8. b. Physician's signature	Date  0 4 7	M (M)	0/00
Send completed forms to: State Legal Departs	Medical Board of Ohio	And Annual Control of the Control of	and the second s
30 E. Broad S			



# State Medical Board of Ohio State Medical Board of Ohio State State Medical Board of Ohio State State

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	0 E	00	2024
	Month	Day	Year
2. Name of medical practice or facility at which F Planned Parent hood		vided:	
3. Address of medical practice or facility at which			
2314 Auburn Ave.	Cincinn	inti OH	45219
4. Date post RU-486 complication began: 0分しょく 2024 、			
5. Event(s) (Please check all that apply):			
Incomplete abortion Adverse r	eaction to RU-486	Patient hospit	alized
Patient received a transfusion Severe bleeding			
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:			
		فتنطق يهموا فميها التحافر	
8. a. Name of physician who provided RU-486	Pr. 6	ent-	
8. b. Physician's signature  Date	09/2		00/00

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3<sup>rd</sup> Floor



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		08	08	2024
2. Name of medical practice or formal Parentl	ecility at which RU-486	onth 5 was provide	Day :cd:	Year
3. Address of medical practice or 2314 Auburn		•		
4. Date post RU-486 complication	- Annual Control of the Control of t			
5. Event(s) (Please check all that a	apply):Adverse reaction	to RU-486	_ Patient hospitalized	
Patient received a transfusion Other serious event (specify)				
6. Duration of event: 2	Hours Days			
7. Remarks:				
8. a. Name of physician who provi		D(.fone	MD)	0.0
30 E.	State Medical Board Department Broad St., 3 <sup>rd</sup> Floor		rate N	SEP 2 4 2024 MEDICAL BOARD OF OHIO



### State Medical Board of Ohio STATE TAKE THE TAKE OF ONLY Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	O-o	09	2024
	Month	Day	Year
2. Name of medical practice or facility at which Planned Parent Nood		rided:	
3. Address of medical practice or facility at which			45219
4. Date post RU-486 complication began: $\mathcal{O}$	13/24		
5. Event(s) (Please check all that apply):			
Incomplete abortion Adverse	reaction to RU-486	Patient hospita	plized
Patient received a transfusionSevere bleeding			
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:		and the second s	
8. a. Name of physician who provided RU-486	DV. Pi	nsde	
8. b. Physician's signatureDat	te [0]4		B/DO
Send completed forms to: State Medic	cal Board of Ohio	NACTOR STREET	

Legal Department

30 E. Broad St., 3<sup>rd</sup> Floor



### State Medical Board of Ohio Tare Dischard De Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	9	15	24
	Month	Day	Year
2. Name of medical practice or facility a Planned Parent		vided:	
3. Address of medical practice or facility	at which RU-486 was pr	ovided:	
2314 Auburn A	Ve Cincin	nati OH	45219
4. Date post RU-486 complication began 914179	:		
5. Event(s) (Please check all that apply):			
Incomplete abortion	_Adverse reaction to RU-486	Patient hospit	alized
Patient received a transfusion Severe b	bleëding		
Other serious event (specify)			
6. Duration of event:Hours	Days		
7. Remarks:			
8. a. Name of physician who provided R	U-486 DV. Y	nsile	
8. b. Physician's signature	Date 10	4/24	0,40.0
Send completed forms to: Stat	te Medical Board of Ohio	Ġ	and the second section of the section of the second section of the section of the second section of the
Legal Depa	rtment		
30 E. Broad	St., 3rd Floor		



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	g	5	24
	Month	Day	Year
2. Name of medical practice or facility at a Plunned Parent )		ovided:	
3. Address of medical practice or facility at 2314 AUDURN AV			45219
4. Date post RU-486 complication began:	10111124		
5. Event(s) (Please check all that apply):		-	
Incomplete abortion A	dverse reaction to RU-486	Patient hosp	italized
Patient received a transfusion Severe ble Other serious event (specify)			
6. Duration of event: 7 Hours	Days		
7. Remarks:			
8. a. Name of physician who provided RU-	486 <u>D</u> (	Liner	
8. b. Physician's signature	Date —	10/29/24	1.0 / 0.0
Send completed forms to: State	Medical Board of Ohi	0	
Legal Departr	ment		
30 E. Broad S	t., 3 <sup>rd</sup> Floor		
Columbus, Ol	H 43215-6127		

DEC 1 1 2024

STATE MEDICAL BOARD OF ONIG



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

(Required pursuant to R.C. 2919:123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	9	U	24
	Month	Day	Year
2. Name of medical practice or facility at who Plunned Parent No		ided:	
3. Address of medical practice or facility at w			45219
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Incomplete abortion Adv	erse reaction to RU-486	Patient hospita	alized
Patient received a transfusion Severe bleed	lng		
Other serious event (specify)			
6. Duration of event: Hours	Days		essentiti - s man acando af a sel (1977). É maganina a compressa a acando a
7. Remarks:			
8, a. Name of physician who provided RU-48	86 DV. 901	Sahane	
8. b. Physician's signature	Date	10/4/20/3	0/10.0
Send completed forms to: State M	ledical Board of Ohio		
Legal Departm	ent		
30 E. Broad St.	, 3 <sup>rd</sup> Floor		



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	09	1 (0	2024
	Month	Day	Year
2. Name of medical practice or facility at which Planned Parent hoo		vided:	
3. Address of medical practice or facility at wh	·		
2314 Auburn Ave.	Cincinn	noti OH	45219
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Incomplete abortion Adver	se reaction to RU-486	Patient hospit	talized
Patient received a transfusion Severe bleedin	g		
Other serious event (specify)			
6. Duration of event: 2 Hours	Days		
7. Remarks:	, , , , , , , , , , , , , , , , , , , ,	***************************************	
8. a. Name of physician who provided RU-486	Dr. Pens	alc	
8. b. Physician's signature	Pate 10 29	124 M	2/00
Send completed forms to: State Med	dical Board of Ohio	)	
Legal Departmen	nt		

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

DEC 1 1 2024

STATE MEDICAL BOARD OF UNIO



# State Medical Board of Ohio $^{\text{State}_{\text{RPPM}}}$ consists Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	9	10	24
	Month	Day	Year
2. Name of medical practice or facility at w Plunned Parent N		ed:	
3. Address of medical practice or facility at a 2314 AUDURN AVE			45219
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Incomplete abortionAd	verse reaction to RU-486	Patient hospiț	alized
Patient received a transfusion Severe blee	ding		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:			
8, a. Name of physician who provided RU-4	186 D1. Pas	ale	
8. b. Physician's signature	Date 1014	1241 (M	p/00
Send completed forms to: State N	Medical Board of Ohio		
Legal Departn	nent		
30 E. Broad St	., 3 <sup>rd</sup> Floor		



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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	9	17	24
	Month:	Day	Yéár
2. Name of medical practice or facility a Planned Parent		ded:	
3. Address of medical practice or facility	at which RU-486 was prov	/ided:	
2314 Auburn A	ve Cincinn.	it' of	45219
4. Date post RU-486 complication began	:		
5. Event(s) (Please check all that apply):			
/Incomplete abortion	Adverse reaction to RU-486	Patient hospiti	alized
Patient received a transfusion Severe b	oleeding		
Other serious event (specify)			
6. Duration of event: Hours	Days	- Martin and the second of the second or second	
7. Remarks:		. Store makestanian	The Administration of
8. a. Name of physician who provided R	U-486 DV. Pin	Sil-	
8. b. Physician's signature	0	4/24	0/100
	te Medical Board of Ohio	**************************************	
Legal Depa			
30 E. Broad	l St., 3 <sup>rd</sup> Floor		



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	9	20	24
	Month	Day	Year
2. Name of medical practice or facility at which Planned Parent Noc	•	ded:	
3. Address of medical practice or facility at wh	•		45219
4. Date post RU-486 complication began: 9 レケーレー			
5. Event(s) (Please check all that apply):			
Incomplete abortion Adver	se reaction to RU-486	Patient hospit	alized
Patient received a transfusion Severe bleedin	g		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:			· · · · · · · · · · · · · · · · · · ·
8. a. Name of physician who provided RU-486	Dr. Note	яИ	
8. b. Physician's signature	Pate ( & (	M.	D./D.O
Send completed forms to: State Med	dical Board of Ohio		The state of the s
Legal Departmen	nt		
30 E. Broad St., 3	<sup>ਰ</sup> Flöor		

Columbus, OH 43215-6127

DEC 2 6 2024



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	10	17	24
	Month	Day	Year
2. Name of medical practice or facility at what Plunned Parent he	•	ded:	
3. Address of medical practice or facility at v	vhich RU-486 was prov	vided:	
2314 Auburn Ave	Cincinn.	nti OH	45219
4. Date post RU-486 complication began:			
11/20/24		SCOOLS St. MARKET ST.	
5. Event(s) (Please check all that apply):			
Incomplete abortion Adv	erse reaction to RU-486	Patient hospita	lized
Patient received a transfusion Severe bleed	ling		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks:		and and a first the second	
8. a. Name of physician who provided RU-48	36 Dr. Perusa	<u>.</u>	
8. b. Physician's signature		- Mi	5/100
	Date 12 5	24	
Send completed forms to: State M	edical Board of Ohio		
Legal Departme	ent		
30 E. Broad St., 3 <sup>rd</sup> Floor			
Columbus, OH	43215-6127	DEC 2	6 2024

STATE MEDICAL BOARD OF ONE



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	(o	21	24
	Month	Day	Year
2. Name of medical practice or facility at which F Planned Parent hood		vided:	
3. Address of medical practice or facility at which	RU-486 was pr	ovided:	
2314 Auburn Ave.			45219
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Adverse r	eaction to RU-486	Patient hospit	əlized
Patient received a transfusion Severe bleeding			
Other serious event (specify)			Property and the second
6. Duration of event: Hours	Days		
7. Remarks:			
8. a. Name of physician who provided RU-486	DUT	un ev	
8. b. Physician's signature			0.01
Date	1/19/	124	<i></i>
Send completed forms to: State Medica	al Board of Ohio	0	
Legal Department			
30 E. Broad St., 3 <sup>rd</sup> F	loor		
Columbus, OH 432:	15-6127		

DEC 1 1 2024



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	lo	21	24
	Month	Day	Year
2. Name of medical practice or facility at which Plunned Parent hood			
3. Address of medical practice or facility at which	h RU-486 was provided	d:	
2314 Auburn Ave.	Cincinnati	OH	45219
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Incomplete abortion Adverse	reaction to RU-486	Patient hospita	slized
Patient received a transfusion Severe bleeding			
Other serious event (specify)			Action & Martin Control of Contro
6. Duration of event: Hours	Days		
7. Remarks:	**************************************		
8. a. Name of physician who provided RU-486	Dr. Liner		
8. b. Physician's signature	•	(M	2/00
Dai	te		11119/24
Send completed forms to: State Medi	cal Board of Ohio		
Legal Department			
30 E. Broad St., 3 <sup>rd</sup> Floor			
Columbus, QH 432	•		

DEC 1 1 2024

STATE MEDICAL BOARD OF OHIO



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:		13	24
	Month	Day	Year
2. Name of medical practice or facility: Planned Parent		vided:	
3. Address of medical practice or facility	at which RU-486 was pr	ovided:	
2314 Auburn 1	re Cincinn	nati OH	45219
4. Date post RU-486 complication began	า:		
5. Event(s) (Please check all that apply):			
Incomplete abortion	_ Adverse reaction to RU-486	Patient hospita	alízed
Patient received a transfusion Severe	bleeding		
Other serious event (specify)			Andrews Same and Angree
6. Duration of event: 2 Hours	Days		
7. Remarks:	-		
8. a. Name of physician who provided R	U-486 <u> </u>	Jursahaney-	
8. b. Physician's signature	Muss Date	12/11/202	9/0.0_
Send completed forms to: Sta	te Medical Board of Ohio	)	
Legal Depa	rtment		
30 E. Broad	St., 3 <sup>rd</sup> Floor	ner 1	6 2024
Columbus.	OH 43215-6127	DEC (	W GUL!

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