



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	03	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <i>Planned Parenthood of Greater Ohio</i>			
3. Address of medical practice or facility at which RU-486 was provided: <i>3255 E. Main St. Columbus OH 43213</i>			
4. Date post RU-486 complication began: <i>01/12/2024</i>			
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: <i>PF received Mife per FDA regulations on 1/5/24. PF called on-call provider d/f complication sx & was sent to the ER. Retained providers products & found.</i>			
8. a. Name of physician who provided RU-486 <u><i>Courtney Kerestes</i></u>			
8. b. Physician's signature <u><i>[Signature]</i></u> (M.D./D.O.)			
Date <u><i>3/18/24</i></u>			

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

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: 01 / 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:
3255 E. Main St. Columbus OH 43213

4. Date post RU-486 complication began: 2/22/24

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:
Failed MAB procedure, surgical AB provided.

8. a. Name of physician who provided RU-486 Dr. Anne Marie Sina

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

Date 2/22/24

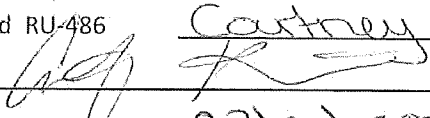
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OCT 22 2024
 STATE MEDICAL BOARD OF OHIO

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:	February	09	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	Planned Parenthood of Greater Ohio - East Columbus Surgical Center		
3. Address of medical practice or facility at which RU-486 was provided:	3255 E Main Street 43213 Columbus, OH		
4. Date post RU-486 complication began:	03/01/2024		
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:	Patient presented for medication abortion follow up on 03/01/2024 due to ongoing pregnancy symptoms (nausea, vomiting, breast tenderness). Repeat ultrasound confirmed ongoing pregnancy. Uterine suction procedure performed by Courtney Kerestes, MD on 03/01/2024.		
8. a. Name of physician who provided RU-486	Courtney Kerestes		
8. b. Physician's signature	 M.D./D.O.		
	Date	03/01/2024	

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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:	<u>February 20 2024</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	Planned Parenthood of Greater Ohio - East Columbus Surgical Center
3. Address of medical practice or facility at which RU-486 was provided:	3255 E Main Street 43213 Columbus, OH
4. Date post RU-486 complication began:	<u>03/01/2024</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:	Patient presented for medication abortion follow up on 03/01/2024. due to pelvic pain. Repeat ultrasound confirmed failed MAB. Fetus w/o cardiac activity. uterine suction procedure performed by Haverly Snyder, MD on 03/01/2024.
8. a. Name of physician who provided RU-486	<u>Haverly Snyder</u>
8. b. Physician's signature	<u>[Signature]</u> (MD/DO)
Date	<u>03/01/2024</u>

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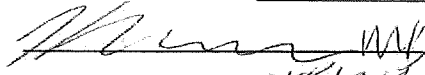
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STATE MEDICAL BOARD OF OHIO

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	28	
	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: 3255 E Main St, Columbus, OH 43213			
4. Date post RU-486 complication began: 3/6/24			
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) <u>hematometra</u>			
6. Duration of event: <u>1</u> Hours <u> </u> Days			
7. Remarks: Patient came in with severe abdominal pain. Ultrasound was performed. Patient was seen to have blood in uterus. Uterine aspiration performed.			
8. a. Name of physician who provided RU-486 <u>Dr. Kale Turner</u>			
8. b. Physician's signature <u></u> <u>M.D./D.O.</u>			
Date <u>3/6/24</u>			

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STATE MEDICAL BOARD OF OHIO

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>3</u> / <u>1</u> / <u>2022</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:	3255 E Main St, Columbus, Ohio 43213
4. Date post RU-486 complication began:	
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 procedure initiated per FDA regimen on 3/1/22. Patient called emergency RN line 3/1/22 reporting heavy bleeding & cramping. US revealed continuing pregnancy. Surgical aspiration performed 3/1/22.
8. a. Name of physician who provided RU-486	<u>Dr. Rivlin</u>
8. b. Physician's signature	<u>[Signature]</u> M.D./D.O. <u>MD</u>
	Date <u>3/1/22</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: Apr 11 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:
3255 E. Main St. Columbus OH 43213

4. Date post RU-486 complication began:
May 03, 2024

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:
Patient had retained products, Dr Kerestes provided another dosage of Mifepristone

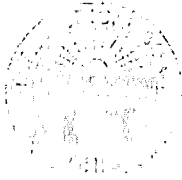
8. a. Name of physician who provided RU-486: Dr Colin McClurey

8. b. Physician's signature: [Signature] (M.B./P.O.)

Date: 5/13/24

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To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<div style="text-align: center; border-bottom: 1px solid black;">May 20, 2024</div> <div style="display: flex; justify-content: space-around; font-size: small;"> Month Day Year </div>
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:	3255 E. Main St Columbus, OH 43213
4. Date post RU-486 complication began:	<div style="text-align: center; border-bottom: 1px solid black;">May 20, 2024</div>
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:	<input type="text" value="1"/> Hours <input type="text" value=""/> Days
7. Remarks:	
8. a. Name of physician who provided RU-486	<div style="text-align: center; border-bottom: 1px solid black;">Colin McCluney MD</div>
8. b. Physician's signature	<div style="text-align: center;"> <div style="display: flex; justify-content: space-between; align-items: center;"> Date 7/29/2024 M.D./D.O. </div> </div>

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STATE MEDICAL BOARD OF OHIO



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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<div style="display: flex; justify-content: space-around; align-items: center;"> May 20 2024 </div> <div style="display: flex; justify-content: space-around; font-size: 0.8em; margin-top: 5px;"> Month Day Year </div>
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:	3255 E. Main St. Columbus OH 43213
4. Date post RU-486 complication began:	June 7, 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 0 Days
7. Remarks:	Patient had retained products. Dr Westes performed procedural BDC
8. a. Name of physician who provided RU-486	PAUL McCLUNY
8. b. Physician's signature	 Date: 6/10/24 M.D./D.O.

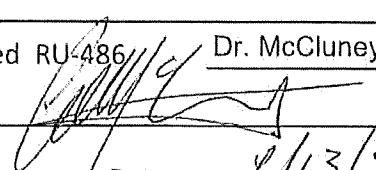
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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	5	23	2022
	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: 3255 E. Main St. Columbus, Oh 43213			
4. Date post RU-486 complication began: 5/31/22			
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 AB/Ectopic pregnancy</u>			
6. Duration of event: <u>1</u> Hours <u> </u> Days			
7. Remarks: MAB procedure was initiated per FDA regimen on 5/23/22. Pt. called 5/27/22 to report little to no bleeding. US performed 5/31/22 revealed definite ectopic pregnancy. Pt. referred to hospital for treatment.			
8. a. Name of physician who provided RU-486 <u>Dr. McCluney</u>			
8. b. Physician's signature  <u>M.D./D.O.</u>			
Date <u>6/13/2022</u>			

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To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	5	31	2022
	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:
3255 E Main St. Columbus, Oh 43213

4. Date post RU-486 complication began:
7/8/2022

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

Incomplete abortion Adverse reaction to RU-486 Patient hospitalized

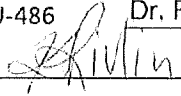
Patient received a transfusion Severe bleeding

Other serious event (specify) Intrauterine Debris

6. Duration of event: 1 Hours _____ Days

7. Remarks: MAB procedure was initiated per FDA regimen on 5/31/2022. Pt. called on 7/8/22 with c/o of +PTU. US performed on 7/8/22 revealed intrauterine debris. Misoprostol was provided. Pt. returned on 7/15/22; US revealed empty uterus.

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

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

Date 8/9/2022

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

OCT 22 2024
STATE MEDICAL BOARD OF OHIO

Prescribed: 5/1/2011, 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: 07 09 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:
3255 E. Main St. Columbus OH 43213

4. Date post RU-486 complication began: 8.23.24

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:
Pt. had POC remaining on FU visit, additional miso was given

8. a. Name of physician who provided RU-486 Abigail Lowther

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

Date 8/27/24

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OCT 22 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: 06/25/2024
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:
3255 E. Main St. Columbus OH 43213

4. Date post RU-486 complication began: 08/05/2024

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: MAB on 06/25/24, follow up ultrasound on 08/23/24 confirmed continuing pregnancy at 17w 3d. Dilation and Evacuation performed on 08/23/24 by Courtney Kerestes, MD.

8. a. Name of physician who provided RU-486 Abigail Louther

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

Date 8/27/24

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OCT 22 2024



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To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	8	9	2022
	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: 3255 E Main St. Columbus Ohio 43215			
4. Date post RU-486 complication began: 8/13/2022			
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>ectopic pregnancy</u>			
6. Duration of event: <u>1</u> Hours _____ Days			
7. Remarks: Mab procedure was initiated per FDA regimen on 8/9/2022. Hcg values were followed due to inconclusive US. Pt. was seen in ER on 8/13/2022 and ectopic pregnancy was confirmed. Patient was treated at Emergency room for resolution of ectopic pregnancy.			
8. a. Name of physician who provided RU-486 <u>Dr. Rivlin</u>			
8. b. Physician's signature <u><i>Adarsh E. Keerthi</i></u> M.D./D.O.			
Date <u>10/14/2022</u>			

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To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 08 / 27 / 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:
3255 E. Main St. Columbus OH 43213

4. Date post RU-486 complication began: 10/01/2024

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: MAB on 08/27/2024. Follow up ultrasound on 10/01/2024 showed persistent viable intra-uterine pregnancy at 12w 5d. Vacuum aspiration procedure performed on 10/07/2024 by Colin McClurey, MD.

8. a. Name of physician who provided RU-486 Abigail Lowther

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

Date _____

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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:	August <small>Month</small>	27 <small>Day</small>	2024 <small>Year</small>
2. Name of medical practice or facility at which RU-486 was provided: <i>Planned Parenthood of Greater Ohio</i>			
3. Address of medical practice or facility at which RU-486 was provided: <i>3255 E. Main St. Columbus OH 43213</i>			
4. Date post RU-486 complication began: <i>10/01/2024</i>			
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: <i>MAB on 08/27/2024. Follow up ultrasound on 10/02/2024 showed persistent viable intra-uterine pregnancy at 12w5d. Vacuum aspiration procedure performed on 10/07/2024 by Colin McClurey, MD.</i>			
8. a. Name of physician who provided RU-486 <u><i>Abigail Lowther</i></u>			
8. b. Physician's signature <u><i>[Signature]</i></u> <small>(M.D./D.O.)</small>			
Date <u><i>10/15/24</i></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: 08 29 24
8/29/24
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:
3255 E. Main St. Columbus OH 43213

4. Date post RU-486 complication began:
10/4/24

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: MAB on 8/29/24, follow-up ultrasound on 10/04/24 shows incomplete abortion, uterine suction procedure performed on 10/04/24 by Courtney Kerestes, MD.

8. a. Name of physician who provided RU-486 Anne-Marie Sinay, MD

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

Date _____

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