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) 12 (Day) 2024 (Year)

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

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

4. Date post RU-486 complication began: 3.19.24

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 0 Days

7. Remarks:
PT C returned Tiime. Now non-viable pregnancy.
Ref'd for D&C

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

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

Date 3.20.24

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

APR 19 2024
STATE MEDICAL BOARD OF OHIO

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

YCH, LLC
6721 Karl Rd
Cols., Oh 43229

COLUMBUS OH 430
16 APR 2024 PM 6 L

State Medical Board of Ohio
Legal Dept.
30 E. Broad st., 3rd floor
Cols., Oh 43215-6127

APR 19 2024
STATE MEDICAL BOARD OF OHIO

43215-612799

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) 11 (Day) 2024 (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):

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: 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.

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

APR 15 2024
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) 17 (Day) 2024 (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):

__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:
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 Zavidan Vickery

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

Date 4/8/2024

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

PPGOH
25350 Rockside Rd
Bedford Hts., OH 44146

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

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APR 09, 2024

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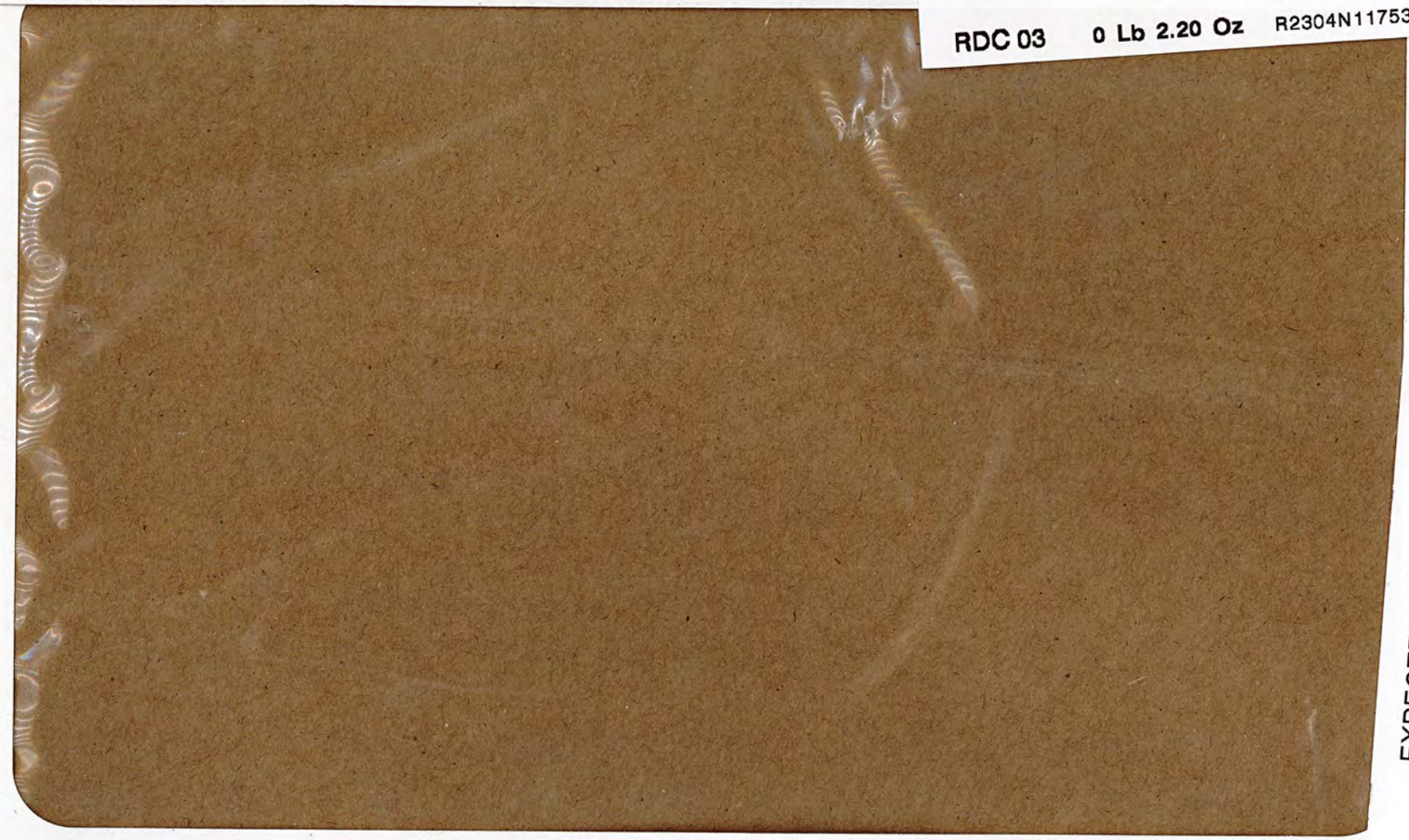

EXPECTED DELIVERY DAY: 04/11/24

USPS TRACKING® #

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APR 15 2024
STATE MEDICAL BOARD OF OHIO

FLAT RATE ENVELOPE

ONE RATE ■ ANY WEIGHT

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) 11 (Day) 24 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Northeast Ohio Women's Center

3. Address of medical practice or facility at which RU-486 was provided:
2167 State Rd, Cuyahoga Falls OH, 44223

4. Date post RU-486 complication began:
3/13/24

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: _____ Hours _____ Days

7. Remarks: Med AB on 3/11/24 - failed
Readministered on 3/13/24 - failed
Successful D&C on 3/22/24

8. a. Name of physician who provided RU-486 ~~Dr~~ David Burkons

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

Date 4/5/24

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

APR 12 2024
STATE MEDICAL BOARD OF OHIO

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

Northeast Ohio Women's Center
2127 State Rd
Cuyahoga Falls, OH 44223

CLEVELAND OH 440
9 APR 2024 PM 1 L

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

APR 12 2024
STATE MEDICAL BOARD OF OHIO

43215-612799

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):

___ 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: 1 Hours _____ 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 _____ MD/DO

Date 4/4/2024

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

APR 11 2024
STATE MEDICAL BOARD OF OHIO

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25350 Rockside Rd
Bedford Hts., OH 44146

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Columbus, OH 43215-6127

APR 11 2024
STATE MEDICAL BOARD OF OHIO

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PM
SOLON, OH 44139
APR 06, 2024

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EXPECTED DELIVERY DAY: 04/08/24

USPS TRACKING® #

APR 11 2024

FLAT RATE ENVELOPE

ONE RATE ■ ANY WEIGHT

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) 22 (Day) 24 (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:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
2/28/24

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

Y 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:

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

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

Date 3/5/24

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

APR 0 2 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: 1 (Month) / 10 (Day) / 24 (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:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
1/17/24

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: 2 Hours _____ Days

7. Remarks:

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

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

Date 1/24/24

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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: 11 (Month) 20 (Day) 23 (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:
2314 Auburn Ave. Cinci, 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 hospitalized

___ Patient received a transfusion ✓ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: _____ Hours 1 Days

7. Remarks:

8. a. Name of physician who provided RU-486 D. Lins

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

Date 1/19/24

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

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Cincinnati Ohio 45219

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STATE MEDICAL BOARD OF OHIO

43215-612799

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

MAR 26 2024
STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided: Feb (Month) 12 (Day) 2024 (Year)

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

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

4. Date post RU-486 complication began: 2-26-24

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

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

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours 0 Days

7. Remarks: Pt did not continue protocol after ultrasound. Pregnancy remains viable; pt electing to continue pregnancy.

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

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

Date 3.8.24

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

YCH, LLC
6721 Karl Rd.
Cols., Oh 43229

COLUMBUS OH 430
22 MAR 2024 PM 4 L

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of Ohio
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30 E. Broad St., 3rd Floor
Cols., Oh 43215-6127

MAR 26 2024
STATE MEDICAL BOARD OF OHIO

43215-612799

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):

___ 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: ___1___ Hours _____ 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 Bhavik Kumar

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

Date 3/13/2024

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: 12/19/23
   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: 2/26/24

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: ___1___ Hours _____ Days

7. Remarks: Patient had positive HSPT >5 weeks post-MAB. MAB follow-up ultrasound showed continued pregnancy 20.1 weeks with desire to continue pregnancy

8. a. Name of physician who provided RU-486 Ashley Brant

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

Date 2/27/24

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

MAR 11 2024
STATE MEDICAL BOARD OF

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 / 20 / 23
   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: 11/20/2023

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 0 Days

7. Remarks: MAB proced we initiated per FDA regimen on 09/27/2023. Follow up US performed on 11/13 showing continuing pregnancy. Surgical Aspiration performed on 11/20/23.

8. a. Name of physician who provided RU-486 Kate Turner

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

Date 1

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

MAR 1 1 2024
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) 27 (Day) 2023 (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:
1/11/24

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

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

X Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks:
MAB procedure was initiated per FDA regimen on 12/27/23. FU appt 1/11/24 noted a hgb of 6.8 and pt was symptomatic. FU US 1/11/24 revealed incomplete MAB. Pt sent directly to ED for transfusion and given a second dose of misoprostol to take after transfusion to resolve incomplete MAB

8. a. Name of physician who provided RU-486 Bhavik Kumar

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

Date 2/14/24

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

MAR 11 2024
STATE MEDICAL BOARD OF OH

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: 12/27/23
   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: 2/6/24

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:
   MAB initiated per FDA regimen on 12/27/23. Patient had MAB follow up for positive HSPT on 2/6/24. Ultrasound showed possible retained products of conception. Patient had uterine aspiration procedure on 2/12/24. Patient did well post-op

8. a. Name of physician who provided RU-486 Bhavik Kumar

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

Date 2/14/24

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

MAR 11 2024
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	18	23
	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: 12/23/23

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: ___1___ Hours _____ Days

7. Remarks:
MAB initiated, per FDA regimen on 12/18/23. Continued pregnancy shown on ultrasound 12/23/23

8. a. Name of physician who provided RU-486 Emily Freeman

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

Date 1/29/24

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

PP0741
25350 Rockside Rd
Bedford Hts., OH 44146

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Columbus, OH 43215-6127

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MAR 06, 2024

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MAR 11 2024

STATE MEDICAL BOARD OF OHIO

EXPECTED DELIVERY DAY: 03/08/24

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LAT RATE ENVELOPE

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State Medical Board of Ohio
Report of RU-486 Event

FEB 21 2024

STATE MEDICAL BOARD OF OHIO

(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) 19 (Day) 2024 (Year)

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

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

4. Date post RU-486 complication began:
Jan 25 2024

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 0 Days

7. Remarks: Retained tissue. Ref'd to OBGyn for D&C.

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

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

Date 2.8.2024

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

FEB 21 2024

STATE MEDICAL BOARD OF OHIO

(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) 30 (Day) 2024 (Year)

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

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

4. Date post RU-486 complication began:
2/5/2024

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

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

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours 0 Days

7. Remarks: Failed MAB. Pt going to continue pregnancy.

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

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

Date 2.9.2024

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

YCH, LLC
6721 Karl Rd
Cols, OH
43229

COLUMBUS OH 430
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State Medical Board of Ohio
Legal Dept.
30 E. Broad St. 3rd floor
Cols, OH 43215-6127

FEB 21 2024
STATE MEDICAL BOARD OF OHIO

43215-612799

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

FEB 21 2024

STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided: Jan (Month) 15 (Day) 2024 (Year)

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

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

4. Date post RU-486 complication began: Jan 22 2024

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 0 Days

7. Remarks: Retained tissue Returned for D&C.

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

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

Date 2.12.24

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

YCH, LLC
6721 Karl Rd
Cols, Oh 43229

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FEB 21 2024
STATE MEDICAL BOARD OF OHIO

43215-612799

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: Dec (Month) 11 (Day) 2023 (Year)

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

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

4. Date post RU-486 complication began: 12/18/23

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 0 Days

7. Remarks: PT did not complete protocol after misoprostol + resulted in retained non-viable pregnancy. Ref'd to her OB for D&C

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

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

Date 1-26-24

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

FEB 05 2024
STATE MEDICAL BOARD OF OHIO

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

YCH, LLC
6721 Karl Rd
Cols., Oh 43229

COLUMBUS OH 430
1 FEB 2024 PM 6 L

State Medical Board of Ohio
Legal Dept.
30 E. Broad St. 3rd floor
Cols., Oh 43215-6127

FEB 05 2024
STATE MEDICAL BOARD OF OHIO

43215-612799

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) 4 (Day) 2023 (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:
12/18/23

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) hematometra

6. Duration of event: 1 Hours _____ Days

7. Remarks:
MAB initiated per FDA regimen 11/4/23. Follow up ultrasound preformed on 12/18/23 revealed hematometra. Pt opted for second dose of misoprostol to resolve hematometra.

8. a. Name of physician who provided RU-486 Zevidah Vickery

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

Date 1/16/24

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JAN 23 2024

STATE MEDICAL BOARD OF OHIO

PROH
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Bedford Hts, OH 44146

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Columbus, OH 43215-6101

EXPECTED DELIVERY DAY: 01/20/24

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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: Nov (Month) 14 (Day) 2023 (Year)

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

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

4. Date post RU-486 complication began:
~~11/27/23~~ 12/7/23 (BR)

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

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

___ Patient received a transfusion X Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours 0 Days

7. Remarks:
Pt referred to ED for further management.

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

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

Date 12/11/23

Send completed forms to:

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Columbus, OH 43215-6127

JAN 22 2024
STATE MEDICAL BOARD OF OHIO

6721 Karl Rd
Cols., Oh 43229

COLUMBUS OH 430
16 JAN 2024 PM 2 L

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State Medical Board of Ohio
Legal Dept.
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Cols., Oh 43215

JAN 22 2024
STATE MEDICAL BOARD OF OHIO

43215-612799

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) 16 (Day) 2023 (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:
11/17/23

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, ectopic

6. Duration of event: ___1___ Hours _____ Days

7. Remarks:
US preformed on 11/16/23 unknown location of pregnancy noted. Pt had MAB per FDA regimen on 11/16/23 with FU hcg quants and ectopic precautions. Hcg quant results 11/17/23 showed concern for ectopic pregnancy. Pt referred to ED 11/17/23. 11/17/23 ED US found left tubal ectopic and pt underwent LS left salpingectomy.

8. a. Name of physician who provided RU-486 Bhavik Kumar

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

Date 12/27/23

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Columbus, OH 43215-6127

JAN 08 2024
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: 10/18/2023
   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: 10/27/2023

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: 1 Hours _____ Days

7. Remarks:

RU-486 was administered on 10/18/23 per FDA regimen. Patient had MAB follow-up visit, at this appointment Ultrsound showed continued pregnancy. Patient proceeded with uterine aspiration. Patient did well post-op.

8. a. Name of physician who provided RU-486 Bhavik Kumar

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

Date 12/27/2023

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Legal Department
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Columbus, OH 43215-6127

JAN 08 2024
STATE MEDICAL BOARD OF OHIO

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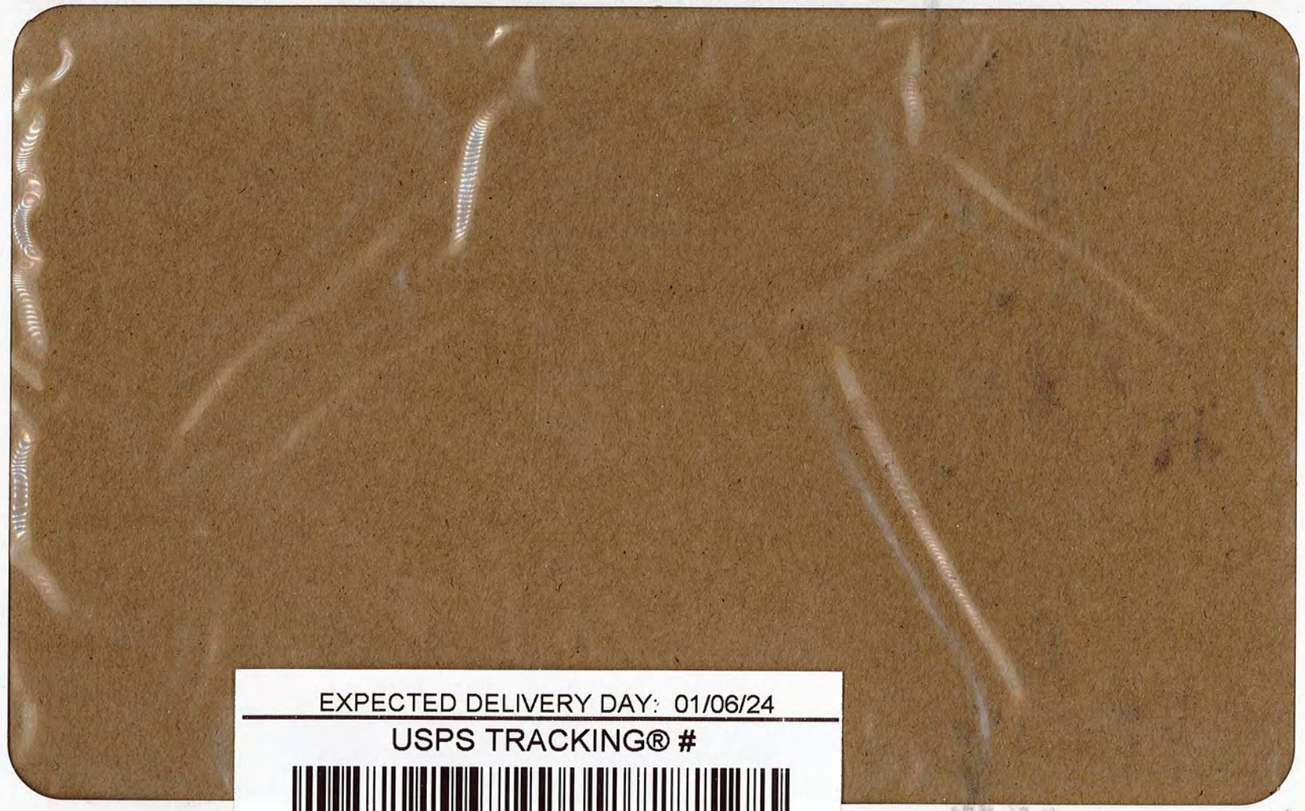

STATE MEDICAL BOARD OF OHIO
JAN 08 2024

EXPECTED DELIVERY DAY: 01/06/24

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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: April (Month) 16 (Day) 2024 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 6711 Karl Rd Columbus OH 43229

4. Date post RU-486 complication began: 4/23/24

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

failed
P Incomplete abortion

___ Adverse reaction to RU-486

___ Patient hospitalized

___ Patient received a transfusion

___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours 0 Days

7. Remarks: Failed MAB. PT returned for surgical AB.

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

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

Date 4.24.24

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OH 43215-6127

MAY 13 2024
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: 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):

___ 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: 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 Ashley Brant M.D. / (D.O.)

Date 5/14/24

Send completed forms to: State Medical Board of Ohio
Legal Department
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Columbus, OH 43215-6127

MAY 17 2024
STATE MEDICAL BOARD OF OHIO

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