

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	Feb	12	2024
	Month	Day	Year
2. Name of medical practice or facili	ty at which RU-486 was provid	led:	
Your Chane Healthe	ar lic		
3. Address of medical practice or faci	lity at which RU-486 was prov	ided:	
	Coluly OH 4322		
4. Date post RU-486 complication be	gan: 3:19.24		
5. Event(s) (Please check all that app	ly):		
/	Adverse reaction to RU-486	Patient hospitalize	d
Patient received a transfusion	Severe bleeding		
Other serious event (specify)			
6. Duration of event: Hou	urs <u> </u>		
7. Remarks: PT & revent Ref'd for	Time. Now now	-min pup	" S.
8. a. Name of physician who provided	I RU-486 WILLIAM	~ roonuc	W)
8. b. Physician's signature ———	/	MD/	.0.0
	Date		
Send completed forms to: State M	edical Board of Ohio		
•	partment		
	oad St., 3 rd Floor Columbus,		APR 19 2024
OH 432	15-6127	STATE	MEDICAL BOARD OF OHIO

YCH, LLC 6721 Karl Rd Cols., Oh 43229

COLUMBUS OH 430°

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State Medical Board & Ohio

Legal Dept. 30 E. Broad St., 3rd Floor Cols., Oh 43215-6127

APR 19 2024

STATE MEDICAL EGA...



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

 Date RU-486 was provided: 	3	11	2024
	Month	Day	Year
Name of medical practice or facility at v Planned Parenthood of Great		led:	
3. Address of medical practice or facility at	t which RU-486 was prov	ided:	
25350 Rockside Road, Be	edford Heights, Ohio, 44146		
4. Date post RU-486 complication began:	4/4/2024		
5. Event(s) (Please check all that apply):			
X Incomplete abortion A	dverse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Severe ble	eding		
Other serious event (specify)			
6. Duration of event:1 Hours	Days		
	024 with E Freeman DO	Patient returned to	clinic on 4/4/2024 for suc
 Remarks: Original MAB AB2 on 3/11/2 procedure for retained POC. 			
procedure for retained POC.	Suction procedure perfor	med by A Potter, M	
	Suction procedure perfor	med by A Potter, M	ID.
procedure for retained POC. 8. a. Name of physician who provided RU- 8. b. Physician's signature Send completed forms to: State	Suction procedure perfor 486 Emily Freema Date Medical Board of Ohio	med by A Potter, Man, DO	ID.
procedure for retained POC. 8. a. Name of physician who provided RU- 8. b. Physician's signature	Suction procedure perforement	med by A Potter, Man, DO	ID.

APR 15 2024



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provide	d:	2	17	2024
T.		Month	Day	Year
Name of medical practice Planned Pare	or facility at which nthood of Greater C		ded:	
3. Address of medical practi	ce or facility at while	ch RU-486 was pro	vided:	
25350 R	ockside Road, Bedford	Heights, Ohlo, 44146		
4. Date post RU-486 complice 2/23/24	cation began:			
5. Event(s) (Please check all	that apply):			
X Incomplete abortion	Advers	e reaction to RU-485	Patient hospita	alized
Patient received a transfusion Other serious event (specify)				
6. Duration of event:1	Hours	Days		
7. Remarks: MAB initiated per FDA regilightheadedness, 10/10 par 2/23/24 pt had D&C, received.	n and soaking 1 pa	d an hour. Pt advise and discharged sar	ne day	th c/o passing large clots, D for urgent evaluation.
8. a. Name of physician who	provided RU-486	Zevidah VI	kery	(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)
8. b. Physician's signature	6	ate 4/8/	2024 W	<u> </u>
Send completed forms to:	State Med	dical Board of Ohio		
	Legal Departmen			
	30 E. Broad St., 3			
	Columbus, OH 4	3215-6127		大学

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

APR 15 2024

STATE MEDICAL BOARD OF OHIO

PPGOH 25350 Duxside Dd Bedford Hts., OH 44146

> State Medical Board of Onio Legal Department 30 E. Brond St., 328 Floor Columbus, OH 43215-6127

> > APR 15 2024

STATE MEDICAL BOARD OF OHIO

PRESS FIRMLY TO SEAL





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04/11/24

PM SOLON, OH 44139 APR 09, 2024

0 Lb 2.20 Oz RDC 03 EXPECTED DELIVERY DAY:

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APR 15 2024

EP14W July 2022 201CAL SOARD OF OHIO OD: 12.5 x 9.5

FLAT RATE ENVELOPE

ONE RATE ANY WEIGHT

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provid	led:	3	11	24
		Month	Day	Year
2. Name of medical practice Northest	11 1	J-486 was provi	ded: Conter	
3. Address of medical pract	ice or facility at which F He Rd, Cuy	RU-486 was prov	vided: OH,	ESSPY
4. Date post RU-486 compli	cation began:	24		
5. Event(s) (Please check all	that apply):			
Incomplete abortion	Adverse rea	ection to RU-486	Patient hospitalized	İ
Patient received a transfusio	n Severe bleeding			
Other serious event (specify)				_
6. Duration of event:	Hours	Days		
7. Remarks: Med &	AB on 3.	111/24 24-fa	- failed led	
Successful	DEC on	32	2129	
8. a. Name of physician who	provided RU-486	PROV	JUID BURK	uns
8. b. Physician's signature	Date -	4/5/m	M.D. /	0.0
Send completed forms to:	State Medical	Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd Flo	or		
	Columbus, OH 43215-	-6127	APR 12	2024

Northeast Olio 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 ST.

APR 12 2024

STATE MEDICAL BOARD OF OHIO

43215-612799

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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:	3/7/24		
	Month	Day	Year
Name of medical practice or facility at w Planned Parenthood of Great		ed:	
3. Address of medical practice or facility at 25350 Rockside Road, Bed		ded:	
4. Date post RU-486 complication began:	3/11/24		
5. Event(s) (Please check all that apply):			
Incomplete abortion Ad	verse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Severe blee	ding		
Other serious event (specify) FA	NILED MAB		
6. Duration of event:1 Hours	Days		
7. Remarks: Mifeprex administered per FDA regimen on 3/7/24. after misoprostol on 3/9. Patient had MAB follow-up 3/11. Did well post-op	Patient took misoprostol on 3/6 US on 3/11 that showed conti	3. Patient called to re nued pregnancy. Pat	port little to no bleeding, ient had D&C Suction
3. a. Name of physician who provided RU-4	mpet	2024	D.O.
Send completed forms to: State M Legal Departm 30 E. Broad St.	, 3 rd Floor		

PPOH BS350 Radside Dd Bedford Hts., OH 44146

> State Medical Board of Ohio Legal Dept. 30 E. Broad St., 3rd Flow Columbus, OH 43215-4127

> > APR 11 2024

STATE MEDICAL BOARD OF OHIO

PRESS FIRMLY TO SEAL





PRESS FI





PM SOLON, OH 44139 APR 06, 2024

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USPS TRACKING® #



APR 11 2024

FLAT RATE ENVELOPE

2022 TARE MEDICAL ROADS OF CHILD ONE DATE - ANY WEIGHT



APR 0 2 2024 State Medical Board of Ohio Report of RU-486 Event 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:	2	22	24
	Month	Day	Year
2. Name of medical practice or facility at Planned Parenthood		ded:	
3. Address of medical practice or facility a 2314 Auburn Au.			
4. Date post RU-486 complication began: 2/28/24			
5. Event(s) (Please check all that apply):			1111 121 11
✓ Incomplete abortion	Adverse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Severe bl	eeding		
Other serious event (specify)			
6. Duration of event: 2 Hours	Days		
7. Remarks:			
3.			
8. a. Name of physician who provided RU	-486	Dr. Limi	
8. b. Physician's signature	Date3/5/	24 M.D.	<u> </u>
Send completed forms to: State	Medical Board of Ohio	***	-

Legal Department

30 E. Broad St., 3rd Floor



APR 0 2 2024 STATE MEDICAL BOARD OF UNIL

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provided:	/	/0	24
	Month	Day	Year
2. Name of medical practice or facility Planned Parenthood	/	ded:	
3. Address of medical practice or facility 2314 Auburn Au			
4. Date post RU-486 complication bega	n:	W	
5. Event(s) (Please check all that apply)			
Incomplete abortion	_ Adverse reaction to RU-486	Patient hospitalize	d
Patient received a transfusion Severe	bleeding		
Other serious event (specify)			
6. Duration of event: Hours	Days		0
7. Remarks:			
0			
. a. Name of physician who provided R	U-486	Kalsy	
. b. Physician's signature	Maly	MAL	0.0
	Date 1 2	1/24	
end completed forms to: Stat	te Medical Board of Ohio		
Legal Depa	rtment		
30 E. Broad	St., 3 rd Floor		



APR 0 2 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:		20	2?
	Month	Day	Year
2. Name of medical practice or facility Planned Parenthood	/	ded:	
3. Address of medical practice or facility 2314 Auburn Au			
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	ı
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 R	U-486	- lins	
B. b. Physician's signature	Date	M.D./1	70
	e Medical Board of Ohio		
Legal Depar			
30 E. Broad	St., 3 rd Floor		

P.O. Box 19797 Cincinnati Ohio 45219 CINCINNATI OH 450

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State Medical Board of Onio
Legal Department
30 E. Broad St. 3rd floor
Columbus, OH

43215 - 4127

APR 0 2 2024 STATE MEDICAL BOARD OF OHIO

43215-612799

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(Required pursuant to R.C. 2919.123)

MAR 2 6 2024

To be completed by the physician who provided RU-486

STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided:	1.0	Feb	12	2024
		Month	Day	Year
2. Name of medical practice or face Your Chaice Healthorn		86 was provide	ed:	
3. Address of medical practice or fa			ded:	
4. Date post RU-486 complication	began: 7-26-24	ľ		
5. Event(s) (Please check all that applicable facility) Incomplete abortion Patient received a transfusion Other serious event (specify)	Adverse reaction	g	_ Patient hospitalized	1
6. Duration of event:	lours <u>O</u> Da	ays		
7. Remarks: Pr did no	ning ville;	preced a	ther nitepu	rere.
8. a. Name of physician who provid 8. b. Physician's signature	ed RU-486		n rassur D/	D.O
Send completed forms to: State	Medical Board of C	Ohio		

Legal Department

30 E. Broad St., 3rd Floor Columbus,

OH 43215-6127

YCH, LLC 16721 Karl Rd. Cols., Oh 43229



State Medical Board

Of Ohio

STATE MEDICAL BOARD OF OHIO

30 E. Broad St., 3rd Floor

Cols., Oh 43215-10127

43215-612799

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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:	02	15	2024
	Month	Day	Year
Name of medical practice or facility at w Planned Parenthood of Grea		ded:	
3. Address of medical practice or facility at	which RU-486 was prov	rided:	
25350 Rockside Road, Bed	dford Heights, Ohio, 44146		
4. Date post RU-486 complication began: 3/2/24			
5. Event(s) (Please check all that apply):			
Incomplete abortion Ad	lverse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Severe blee	eding		
X Other serious event (specify) Failed Abortio	n		
6. Duration of event:1 Hours	Days		
7. Remarks:			
MAB procedure initiated per FHD regimen of continuing pregnancy. Pt opted for second	on 2/15/24. Follow up ultr dose of MAB medications	rasound preformed s.	on 3/2/24 revealed
8. a. Name of physician who provided 70-4	186 Bhavik Kuma	ar	
8. b. Physician's signature	Date 3 1/3 1	2024 2024	/ D.O
	Date 3 / 13 / 1	-	

30 E. Broad St., 3rd Floor

(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
Name of medical practice or facilit Planned Parenthood of		ed:	
3. Address of medical practice or facil	ity at which RU-486 was provi	ded:	
4. Date post RU-486 complication beg			
5. Event(s) (Please check all that apply	y):		
Incomplete abortion	Adverse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Seve	re bleeding		
X Other serious event (specify)	ortion		
6. Duration of event:1 Hou	rs Days		
7. Remarks: Patient had positive HSPT weeks with desire to continu	>5 weeks post-MAB. MAB follow-up ue pregnancy	ultrasound showed co	ontinued pregnancy 20.1
8. a. Name of physician who provided 8. b. Physician's signature	Selleur	m.D.,	/ D.O
	tate Medical Board of Ohio		
- 1.5700 A	partment pad St., 3 rd Floor		

Columbus, OH 43215-6127

MAR 1 J 2024 STATE MEDICAL BOARD O



(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	123	
	Month	Day	Year
Name of medical practice or facility Planned Parenthood of G		vided:	
Address of medical practice or facility 25350 Rockside Road	y at which RU-486 was pr		
4. Date post RU-486 complication bega	n: 11/w/2023		
5. Event(s) (Please check all that apply):			
Incomplete abortion	_ Adverse reaction to RU-486	Patient hospitali	zed
Patient received a transfusion Severe Other serious event (specify)		Housing	
6. Duration of event:1 Hours	Days		
7. Remarks: MAD proced we in Foliow up us performed on Sussical Aspiration	nitiated per FD. 11/13 showing performed on	A regimon continuing p	on 09/27/2023.
3. a. Name of physician who provided R 3. b. Physician's signature	1/ 1.	urner	/D.O
Activities Constitution of the Constitution of	te Medical Board of Ohio		
Legal Depa	rtment I St., 3 rd Floor	MAI	2 1 1 200).

Columbus, OH 43215-6127

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 provid	led:	12	27	2023
		Month	Day	Year
2. Name of medical praction Planned Par	ce or facility at which Renthood of Greater Ohi		led:	
3. Address of medical pract	cice or facility at which		ided:	
4. Date post RU-486 compl 1/11/24	ication began:			
5. Event(s) (Please check al	l that apply):			
X Incomplete abortion	Adverse re	eaction to RU-486	Patient hospitalize	d
6. Duration of event:	Hours	_ Days		
7. Remarks: MAB procedure was initiat symptomatic. FU US 1/11/dose of misoprostol to take	24 revealed incomplete	MAB. Pt sent dire	ctly to ED for transfi	b of 6.8 and pt was usion and given a secon
3. a. Name of physician who	provided RU-488	Bhavily Kuma	ır	
3. b. Physician's signature	Date	2/14/24	M.D. /	D.O
send completed forms to:	State Medica	l Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd Fl	oor		
1	Columbus, OH 4321	5-6127	into	4 4 000

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

MAR 1 1 2024

STATE MEDICAL BOARD OF DE



(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
Name of medical practice or facility at v Planned Parenthood of Great		ed:	
3. Address of medical practice or facility at		ded:	
25350 Rockside Road, Be	edford Heights, Ohio, 44146		
4. Date post RU-486 complication began:	2/6/24		
5. Event(s) (Please check all that apply):			
x Incomplete abortionA	dverse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Severe ble	eding		
Other serious event (specify)			
6. Duration of event:1 Hours	Days		
7. Remarks: MAB initiated per FDA regimen on 12/27/23. Patie	ent had MAB follow up for positi	ve HSPT on 2/6/24. U	Jitrasound showed possible
retained products of conception. Patient had uteri	ne aspiration procedure on 2/12	2/24. Patient did well	post-op
B. a. Name of physician who provided RU-	486 Bhavik Ku	mar	
8. b. Physician's signature	Date 2/14/24	M.D./	<u> </u>
Send completed forms to: State	Medical Board of Ohio		
Legal Departr	ment		

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MAR 1 1 2024

STATE MEDICAL BOARD OF ONIC



(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
Name of medical practice or facility at w Planned Parenthood of Great		ded:	
3. Address of medical practice or facility at	which RU-486 was prov	rided:	
25350 Rockside Road, Bed	ford Heights, Ohio, 44146		
4. Date post RU-486 complication began:	12/23/23		
5. Event(s) (Please check all that apply):			
Incomplete abortion Ad	verse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Severe blee	ding		
X Other serious event (specify) Failed Abortion	on		
6. Duration of event:1 Hours	Days		
7. Remarks: MAB initiated, per FDA regimen on 1	2/18/23. Continued preg	nancy shown on ult	rasound 12/23/23
8. a. Name of physician who provided RU-4 8. b. Physician's signature	86 Emily Freen	19/24 ·	60
Send completed forms to: State N	ledical Board of Ohio		

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MAR 1 1 2024

25350 Dutsde 2d Bedford Hts., OH 44141

State Medical Econd

Legal Department

BOE Broad St. 329 Floor

Colombis OH 43215-6127

PRESS FIRMLY TO SEAL





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RDC 03



SOLON, OH 44139 MAR 06, 2024

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0 Lb 2.70 Oz R2304P118893-07

EXPECTED DELIVERY DAY: 03/08/24

USPS TRACKING® #

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LAT RATE ENVELOPE

E RATE ■ ANY WEIGHT

(Required pursuant to R.C. 2919.123)

FEB 2 1 2024

STATE MEDICAL BOARD OF OHIO

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		Jan	19	2024
		Month	Day	Year
2. Name of medical practice or			d:	
3. Address of medical practice o		U-486 was provid	ed:	
6721 Kaul Rd	•	1 1		
4. Date post RU-486 complication	on began: Jan 25	2024		
5. Event(s) (Please check all that	apply):			
	Adverse rea	ction to RU-486	_ Patient hospitalize	ed
Patient received a transfusion	Severe bleed	ling		
Other serious event (specify)				
5. Duration of event:l	HoursO	Days		
7. Remarks: Retail 1	sine. Ref	ld to OBCa	ge for Do	
3. a. Name of physician who prov	vided RU-486	Willam	Rooom	- wy
3. b. Physician's signature	Date -	2.8.	wy MD/	D.O
	te Medical Board o	f Ohio		
	al Department	6.1		
30 (E. Broad St., 3 rd Floo	or Columbus,		

OH 43215-6127

(Required pursuant to R.C. 2919.123)

FEB 2 1 2024

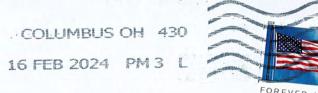
To be completed by the physician who provided RU-486

STATE MEDICAL BOARD OF OHIO

	Jan	30	2024
	Month	Day	Year
2. Name of medical practice or facility at when Your Choice Kaltuca	1	led:	
	19,		
3. Address of medical practice or facility at v	vhich RU-486 was prov	ided:	
6721 Kan Rd Columbus	04 43229		
4. Date post RU-486 complication began:	21512024		
	013 1200 (
5. Event(s) (Please check all that apply):			
P Incomplete abortion Adv	erse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Seve	ere bleeding		
Other serious event (specify)			
			1.
6 Duration of event: Hours	Dave Dave		
6. Duration of event:(Hours	Days		
		Les . Osen	
		ie progni	7.
		ine pungue	<i>a</i> .
	oping to conti		
	oping to conti	ine pungmi	
7. Remarks: Failed MAB. Pt	oping to conti	mason my.	e vs
7. Remarks: Falled MAB. Pt 3. a. Name of physician who provided RU-48 3. b. Physician's signature	apring so contr	.m. nosom	e vs
7. Remarks: Faled MAB. Pt 8. a. Name of physician who provided RU-48 8. b. Physician's signature	oping to control Both Date 2.9.	mason my.	e vs
7. Remarks: Falled MAB. Pt 3. a. Name of physician who provided RU-48 3. b. Physician's signature	oping to control Both Date 2.9.	.m. nosom	e vs
7. Remarks: Faled MAB. Pt 8. a. Name of physician who provided RU-48 8. b. Physician's signature	oping to control Board of Ohio	.m. nosom	e vs

OH 43215-6127

40H.UC 6721 Karl Rd Cols.101 43129



State Medical Board of Ohio legal Dept. 30 E. Broad St. 3rd Hoor cols. 101 43215-4927

FEB 2 1 2024

STATE MEDICAL BOARD OF OHIO

43215-612799

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(Required pursuant to R.C. 2919.123)

FEB 21 2024

To be completed by the physician who provided RU-486

STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provid	led:	Jon	15	rory
		Month	Day	Year
2. Name of medical praction			vided:	
Your Chris	e Mouthane V	LC i		
2. Adduses of wedded weed	daa ay faailitu at uubiah	DI 106 was a	المراجعة الم	
3. Address of medical pract				
67C1 (2001	hoad Columb	1 2	43007	
4. Date post RU-486 compl	ication began: Ja	n zz z	sey	
5. Event(s) (Please check al	l that apply):			
	Adverse	eaction to RIL-496	Patient hospitalize	ad
		200101110110-400	ratient nospitalize	eu
Patient received a transfusion	n Severe ble	eding		
Other serious event (specify				
				- 1
5 Duration of events /	Hauma O			
6. Duration of event:	Hours	_ Days		
7. Remarks:	tismi Rebu	and for	DAG	
vierny	(1)	2007		
3. a. Name of physician who	provided RU-486		to Roonin	- wy
B. b. Physician's signature		1	MD/	D.O.
	Date	2.12.		
end completed forms to:	State Medical Board	of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd Flo	oor Columbus,		
	OH 42215 6127			

YCH, LLC 10721 Karl Rd Cols, Oh 43229

COLUMBUS OH 430 16 FEB 2024 PM 3 L



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

STATE MEDICAL BOARD OF OHIO

49215-612799

1. 40 VALLEY

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		Dec	()	2023
		Month	Day	Year
2. Name of medical practice or f	acility at which RU	J-486 was prov	ded:	
Your Choice	Healthan U	.c .t	ű,	
		100	W. F.	
3. Address of medical practice or b 721 kml md	facility at which F Country Of	RU-486 was pro	vided:	
4. Date post RU-486 complication	n began: 12/(8/23		
5. Event(s) (Please check all that	apply):			
X. Incomplete abortion	Adverse rea	action to RU-486	Patient hospitalize	ed
- Arthur and Arthur and Arthur		X sessional de Vita I de Vita		
Patient received a transfusion	Severe bleed	ding		
	,	+		
Other serious event (specify)				
Other serious event (specify)				
6. Duration of event:	Hours	Days		
7. Remarks: Pt did not	complete pr	otoral after	misepusane .	resitay
in retains	non whe pu	yuz. Ref	y wher of	s for date
3. a. Name of physician who prov	ided RU-486	- will	IAM ROOM	L M
8. b. Physician's signature		1	MD.	/ D.O
	Data	1-2	6.24	
ACCRECATE TO THE	Date -			
Send completed forms to: Stat	e Medical Board o	of Ohio		
Lega	l Department			
30 E	. Broad St., 3 rd Flo	or Columbus,	F	EB 05 2024
ОН	43215-6127		STATE ME	DICAL BOARD OF OHIO

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State Medical Board of Ohio begal Dept.

30 E. Broadst 35d Floor

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STATE MEDICAL BOARD OF CHIO

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

B . Bu 400	11	4	2023
1. Date RU-486 was provided:	Month	Day	Year
Name of medical practice or facility at which Planned Parenthood of Greater C	RU-486 was provi	, , , , , , , , , , , , , , , , , , ,	166)
3. Address of medical practice or facility at which 25350 Rockside Road, Bedford	1		
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	l ,
Patient received a transfusion Severe bleeding	,	<i>I.</i>	
X Other serious event (specify) hematometra			
6. Duration of event: Hours	Days		* 1
7. Remarks: MAB initiated per FDA regimen 11/4/23. Follow Pt opted for second dose of misoprostol to reso	up ultrasound prefo ve hematometra.	ormed on 12/18/23 rev	realed hématometra.
8. a. Name of physician who provided RU-486 8. b. Physician's signature Da	Zeyvidah Vick	(ery , M.D.*/	D.O
Sella completer forms to i	ical Board of Ohio	1 1	
Legal Department	J		
30 E. Broad St., 3 rd	•		
Columbus, OH 43	XT3-0T5\		

JAN 23 2024

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

Date RU-486 was provided:	nhow	. 14	2023	
The state of the s	Month	Day	Year	
2. Name of medical practice or facility at w Low Curin Hallhu	vhich RU-486 was prov	ided:	·	
	\$1			Action to the second se
3. Address of medical practice or facil		was provided:		
4. Date post RU-486 complication beg	Tan 1	A CONTRACTOR OF THE PARTY OF TH		
11/12/123 12/3/23		I		
5. Event(s) (Please check all that apply		+		· ·
	dverse reaction to RU-486	Patient höspitali	zed	
	•			
Patient received a transfusion Severe bl	eeding	2.8		*
		3		
Other serious event (specify)				
5. Duration of event; Hours	O Days		The Street	
7. Remarks:			<u> </u>	
Pt related to	to fur full	u mugunt		
		,		1.
n Nama afinhusisian uda	DU 400		DOM NO	* /
3. a. Name of physician who provided	NO-486	MAM No	om is	1-7-1
3. b. Physician's signature	V _		O.0\d.n	7 .
	Date	11/23		
nd anymistad forwarts				1*
nd completed forms to:	State Medical	Board of Ohio		74.
Le	egal Department		· a	8.
30	F Broad St 2rd Elo	or	+	

Columbus, OH 43215-6127

JAN 2 2 2024 STATE MEDICAL BOARD OF OHIO 6721 Karl Rd cols., Oh 43229

COLUMBUS OH 430 16 JAN 2024 PM 2 L



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

JAN 2 2 2024

STATE MEDICAL BOARD OF OHIO

43215-612799



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was prov	ided:	11	16	2023
		Month	Day	Year
Name of medical pract Planned Page 19 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	tice or facility at which arenthood of Greater Oh		vided:	
3. Address of medical pra	ctice or facility at which			
4. Date post RU-486 com 11/17/23	plication began:			
5. Event(s) (Please check	all that apply):	7		
Incomplete abortion Patient received a transfus		reaction to RU-486	Patient hospita	alized
X Other serious event (speci		Days	T.	· /·
7. Remarks: US preformed on 11/16/23 FU hcg quants and ectopic referred to ED 11/17/23. 12	precautions. Hcg guant	results 11/17/23	showed concern for	A regimen on 11/16/23 with or ectopic pregnancy. Pt left salpingectomy.
8. a. Name of physician w 8. b. Physician's signature	Sh	Bhavik Ku e 12/27/23	umar M.	070.0
Send completed forms to:	State Medic Legal Department 30 E. Broad St., 3 rd I Columbus, OH 432			JAN 08 2024 E 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:		10/18/20	023	
	. 61	Ionth	Day	Year
Name of medical practice or facility at which Planned Parenthood of Greater Ol		86 was pro	vided:	
3. Address of medical practice or facility at whic	100			
4. Date post RU-486 complication began: 10/2	27/2023		v ~	
5. Event(s) (Please check all that apply):				
Incomplete abortion Adverse Adverse Patient received a transfusion Severe bleeding Failed abortion	1	n to RU-486	Patient hospitalize	d
x_ Other serious event (specify) 6. Duration of event:1 Hours	Da	ys	,	1 1
7. Remarks: RU-486 was administered on 10/18/23 per FDA regime continued pregnancy. Patient proceeded with uterine a	en. Pati	ent had MAE n. Patient di	d well post-op.	pointment Ultrsound shower
8. a. Name of physician who provided RN-486 8. b. Physician's signature Dat	\mathcal{I}	Bhavik Kum	1	D.O
Send completed forms to: Legal Department 30 E. Broad St., 3 rd Columbus, OH 432	Floor		JA	N 0 8 2024 ICAL BOARD OF OHIO

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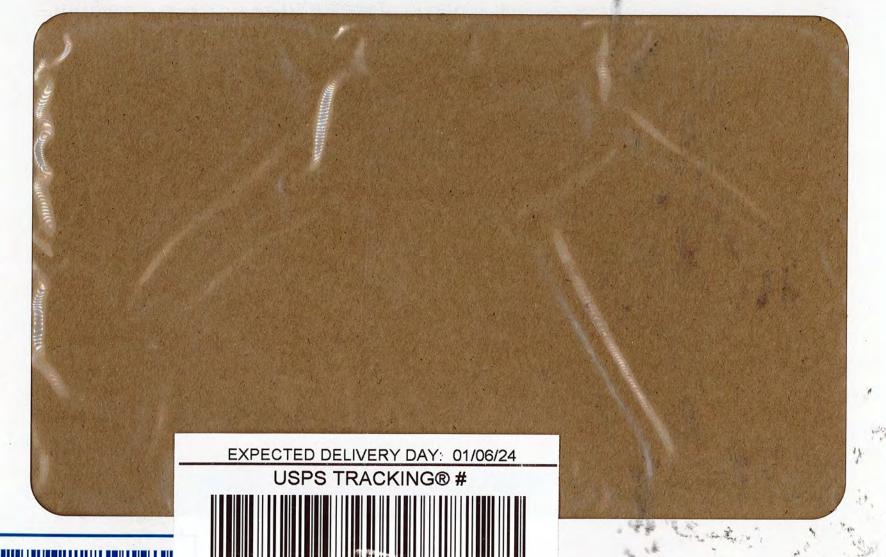
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> JAN U 8 2024 STATE MEDICAL BOARD OF OHIO

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

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

		_April	16	2
2 Nama of	Tar. Victoria de la Constantina del Constantina de la Constantina	Month		2024
2. Name of medical	practice or facility at whi	ich RU-486 was provide	id:	Year
lour	Choic Herthan	· uc	u.	
L2.	practice or facility at wh	nich RU-486 was provide	ed.	
orci ea	of company	OH 43225		
4. Date post RU-486 co		1.40		
S Frankl Mar	4	123/24		
5. Event(s) (Please che	ck all that apply):			
P Incomplete abortion				
	Adverse	e reaction to RU-486	Patient hospitalized	
Patient received a trans			- Spitalized	
- cocioca a trans	Severe b	pleeding		
Other serious event (spe	ecify)			
				-
		_ Days		-
Duration of event:	Hours _ O			
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Duration of event:			AB.	
Duration of event:	Hours _ O		AB.	
Duration of event: Remarks: Faul	Hours 0		AB.	
Duration of event: Remarks: Faul Name of physician wi	Hours 2	retained for sugar		
Duration of event: Remarks: Faul Name of physician wi	Hours 2			
Duration of event: Remarks: Faul	Hours 2	retained for sugar		
Duration of event: Remarks: Faul Name of physician will physician's signature	Hours 2	retained for sign	MD/DO	
Duration of event: Remarks: Faul Name of physician wi	Hours 2 WAY. PT ho provided RU-486 Date	William 4.24.24	MD/DO	
Duration of event: Remarks: Faul Name of physician will physician's signature	Hours 2 WAY. PT ho provided RU-486 Date -	William 4.24.24	MD/DO	
Duration of event: Remarks: Faul Name of physician will physician's signature	Hours 2 MAY. PT ho provided RU-486 Date - State Medical Board of Legal Department	William Y. 24. 24	MD/DO	
Duration of event: Remarks: Faul Name of physician will physician's signature	Hours 2 WAY. PT ho provided RU-486 Date -	William Y. 24. 24	MD/DO	

MAY 1 3 2024

(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	4/30/24		
	Month	Day	Year	
Name of medical practice or facility at wheeler properties of the properties		led:		
3. Address of medical practice or facility at w		ided:		
4. Date post RU-486 complication began:	5/11/24			
5. Event(s) (Please check all that apply):				
Incomplete abortion Adv	erse reaction to RU-486	Patient hospitaliz	ed	
Patient received a transfusion Severe bleed	ling			
X Other serious event (specify) failed MAB			_	
6. Duration of event:1 Hours	Days			
7. Remarks: MAB initiated per FDA regimen on Ultrasound showed continued preg				
8. a. Name of physician who provided RU-48	Ashley E	Brant		
8. b. Physician's signature	Date	M.D.	<u>6</u> 5	
Send completed forms to: State M	ledical Board of Ohio			

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MAY 17 2024